MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

01705
Reg. Dist. No. 97

1708

1. PLACE OF DEATH
a. COUNTY: Cecil — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Bainbridge
c. LENGTH OF STAY IN 1b:
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address): Dead on Arrival at USNH, Bainbridge

2. USUAL RESIDENCE (Where deceased lived. If Institution: Residence before admission)
a. STATE: Maryland — b. COUNTY: Cecil
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): x 2 North East
d. STREET ADDRESS: 1 RD#1
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print): First JAMES — Middle CAMERON — Last ABRAMS

4. DATE OF DEATH: Month February — Day 7 — Year 19 57

5. SEX: Male
6. COLOR OR RACE: Cauc
7. MARRIED ☒ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☐
8. DATE OF BIRTH: 4-3-1899
9. AGE (In years last birthday): 57 yrs.
IF UNDER 1 YEAR: Months / Days
IF UNDER 24 HRS.: Hours / Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Auto Mechanic
10b. KIND OF BUSINESS OR INDUSTRY: U. S. Navy
11. BIRTHPLACE (State or foreign country): Maryland
12. CITIZEN OF WHAT COUNTRY? USA

13. FATHER'S NAME: James W. ABRAMS
14. MOTHER'S MAIDEN NAME: Mollie M. KIRK

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service):
16. SOCIAL SECURITY NO.: 705 12 0158
17. INFORMANT: Navy Records — Address:

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a): CORONARY OCCLUSION — INTERVAL BETWEEN ONSET AND DEATH: Sudden

420.1

DUE TO (b):

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. DUE TO (c):

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(a):

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☒

20a. EXTERNAL CAUSE WAS PRIMARY ☐ or CONTRIBUTING ☐ CAUSE OF DEATH.
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)
20c. TIME OF INJURY: Hour a. m. p. m. — Month, Day, Year 19
20d. INJURY OCCURRED: While at work ☐ Not while at work ☐
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)
20f. (City or town) (County) (State)

21. I certify that I took charge of the remains described above, held an Autopsy ☐, Inspection ☒, Inquiry ☒, and find that death resulted from: Natural causes ☒, Accident ☐, Suicide ☐, Homicide ☐, Undetermined cause ☐.

ACTUAL SIGNATURE: R Dodson M.D. — DATE SIGNED

CHIEF MEDICAL EXAMINER ☐
ASSISTANT MEDICAL EXAMINER ☐
DEPUTY MEDICAL EXAMINER ☒

EXAMINER'S NAME (Type): R. C. DODSON, M.D. — 2-7-57

22a. BURIAL, CREMATION, REMOVAL (Specify): Burial
22b. DATE THEREOF: 2/10/57
22c. NAME OF CEMETERY OR CREMATORY: Bay View Cemetery
22d. LOCATION (City, town, or county) (State): North East, RD#1, Md.

23. FUNERAL DIRECTOR'S SIGNATURE / ADDRESS: Ralph E. Hicks, Elkton, Md.
24a. REC'D BY REGISTRAR DATE: 2-7-57
24b. REGISTRAR'S SIGNATURE: Dorothy B Bramble

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.

VS. A15ME(5)
SM 9/55

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

Item 9 Film 211 2-21-57 et

01706

1692

CERTIFICATE OF DEATH

Reg. Dist. No. 962

1. PLACE OF DEATH
a. COUNTY: Cecil — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Elkton
c. LENGTH OF STAY IN 1b: 3 Weeks
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION: Elkton Hosp.

2. USUAL RESIDENCE (Where deceased lived. If institution, Residence before admission)
a. STATE: Maryland
b. COUNTY: Harford
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Havre de Grace 12.242
d. STREET ADDRESS: 815 Otsego St
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print): First James Middle Arthur Last Barnes

4. DATE OF DEATH: Month 2 Day 12/57 Year 19

5. SEX: Male

6. COLOR OR RACE: White

7. MARRIED ☒ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☐

8. DATE OF BIRTH: July 23-1892

9. AGE (In years last birthday): 64 yrs.

IF UNDER 1 YEAR: Months / Days
IF UNDER 24 HRS.: Hours / Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Oyster Tester

10b. KIND OF BUSINESS OR INDUSTRY: Edgewood Chemical Co.

11. BIRTHPLACE (State or foreign country): Havre de Grace Md

12. CITIZEN OF WHAT COUNTRY? U.S.A.

13. FATHER'S NAME: Geo. Washington Barnes

14. MOTHER'S MAIDEN NAME: Cornelia Dinsmore

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service): Unknown

16. SOCIAL SECURITY NO.: Unknown

17. INFORMANT: Mrs. Lena A. Barnes — Address: 815 Otsego St. Havre de Grace Md.

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a): Coronary thrombosis — INTERVAL BETWEEN ONSET AND DEATH: Two days
DUE TO
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. 420.1
(b)
DUE TO
(c)

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(a)

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☐

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)

20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)

20c. TIME OF INJURY Hour a. m. p. m. Month, Day, Year 19

20d. INJURY OCCURRED While at work ☐ Not while at work ☐

20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)

20f. (City or town) (County) (State)

21. I certify that I attended the deceased from Jan 25, 19 57, to Feb. 12, 19 57, that I last saw the deceased alive on Feb 11, 19 57, and that death occurred at 6:15 A M, from the causes and on the date stated above.

ACTUAL SIGNATURE: S Ralph Andrews Jr. M.D. — ADDRESS (Street, city or town, state): 233 E Main St. Elkton Md — DATE SIGNED: 2/14/57

PHYSICIAN'S NAME (Type): S RALPH ANDREWS JR M.D.

22a. BURIAL, CREMATION, REMOVAL (Specify): Burial
22b. DATE THEREOF: 2/15/57
22c. NAME OF CEMETERY OR CREMATORY: Angel Hill
22d. LOCATION (City, town, or county) (State): Havre de Grace Md.

23. FUNERAL DIRECTOR'S SIGNATURE: Tennyson — ADDRESS: Havre de Grace, Md.

24a. REC'D BY REGISTRAR DATE: 2/13/57
24b. REGISTRAR'S SIGNATURE: Hunt F. Mattingly
P. Rodney Fraser Jr.

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 4 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 3 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A1S (4)
1SM 9/SS

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

01707

• 1709

CERTIFICATE OF DEATH

Reg. Dist. No. 96

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A15 (4)
15M 9/55

1. PLACE OF DEATH
a. COUNTY: Cecil
MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Perry Point
c. LENGTH OF STAY IN 1b: 26yrs10mos30days

2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE: PENNSYLVANIA
b. COUNTY: Erie
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Erie
d. STREET ADDRESS: 534 East 4th Street
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION: Veterans Administration Hospital

3. NAME OF DECEASED (Type or print): First ARVID Middle PALMON Last BRANDT

4. DATE OF DEATH: Month February Day 21 Year 1957

5. SEX: Male
6. COLOR OR RACE: White
7. MARRIED ☐ NEVER MARRIED ☒ WIDOWED ☐ DIVORCED ☐
8. DATE OF BIRTH: October 14, 1895
9. AGE (In years last birthday): 61 yrs.
IF UNDER 1 YEAR: Months / Days
IF UNDER 24 HRS.: Hours / Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Motion Picture Oper.
10b. KIND OF BUSINESS OR INDUSTRY: Theatre
11. BIRTHPLACE (State or foreign country): Sweden
12. CITIZEN OF WHAT COUNTRY?: USA

13. FATHER'S NAME: Unknown
14. MOTHER'S MAIDEN NAME: Unknown

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown): Yes
(If yes, give war or dates of service): WW-I
16. SOCIAL SECURITY NO.: None
17. INFORMANT Address: Hospital Records, VAH., Perry Point, Maryland

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a): Bronchopneumonia bilateral unresolved — INTERVAL BETWEEN ONSET AND DEATH: 7-10 days
491X
DUE TO
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.
(b) Uremia, uremic poisoning (clinical) — unknown
DUE TO
(c) Nephrosclerosis bilateral — unknown

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)

19. WAS AUTOPSY PERFORMED? YES ☒ NO ☐

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)
20c. TIME OF INJURY Hour a. m. p. m. Month, Day, Year 19
20d. INJURY OCCURRED While at work ☐ Not while at work ☐
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)
20f. (City or town) (County) (State)

21. I certify that VA attended the deceased from March 22, 19 30, to February 21, 19 57 ~~last saw the deceased alive on~~ and that death occurred at 12:35 PM, from the causes and on the date stated above.

ACTUAL SIGNATURE: W. Oppler M.D.
ADDRESS (Street, city or town, state): VAH., Perry Point, Md.
DATE SIGNED: 2-25-57

PHYSICIAN'S NAME (Type): W. OPPLER, M.D., Director, Professional Services, VAH., Perry Point, Md.

22a. BURIAL, CREMATION, REMOVAL (Specify): Removal
22b. DATE THEREOF: 2-25-57
22c. NAME OF CEMETERY OR CREMATORY: Baltimore National
22d. LOCATION (City, town, or county) (State): Baltimore, Md.

23. FUNERAL DIRECTOR'S SIGNATURE: [illegible] & Son
ADDRESS: Havre De Grace, Md.
24a. REC'D BY REGISTRAR DATE: 2/27/57
24b. REGISTRAR'S SIGNATURE: Irene E Daughtry

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

CERTIFICATE OF DEATH

1710

Reg. Dist. No. 01708

1. PLACE OF DEATH
a. COUNTY: CECIL — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): CHESAPEAKE CITY
c. LENGTH OF STAY IN 1b:
d. NAME OF HOSPITAL (If not in hospitol, give street oddress) OR INSTITUTION: MORGAN NURSING HOME

2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE: MD — b. COUNTY: KENT
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): KENTMORE PARK
d. STREET ADDRESS: 14X02
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print): First MARY — Middle J. — Last COLGAIN

4. DATE OF DEATH: Month FEB — Day 6 — Year 1957

5. SEX: F.

6. COLOR OR RACE: W

7. MARRIED ☐ NEVER MARRIED ☐ WIDOWED ☒ DIVORCED ☐

8. DATE OF BIRTH: APRIL 21, 1867

9. AGE (In years last birthday): 89 yrs.

IF UNDER 1 YEAR: Months — Days
IF UNDER 24 HRS.: Hours — Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): HOUSEWIFE

10b. KIND OF BUSINESS OR INDUSTRY: HOME

11. BIRTHPLACE (State or foreign country): DEL.

12. CITIZEN OF WHAT COUNTRY? U. S. A.

13. FATHER'S NAME: NEHMIAH CLARK

14. MOTHER'S MAIDEN NAME: ANNIE E. LARRIMORE

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) — (If yes, give war or dates of service) —

16. SOCIAL SECURITY NO.: NONE

17. INFORMANT: MRS. WARREN JOHNSON — Address: GALENA, MD.

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a): uremia — INTERVAL BETWEEN ONSET AND DEATH: 1 Year

4467

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

DUE TO (b): Nephrosclerosis — years

DUE TO (c): Generalized arteriosclerosis — years

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☒

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)

20b. DESCRIBE HOW INJURY OCCURRED. (Enter noture of injury in Part I or Part II of item 18.)

20c. TIME OF INJURY Hour a. m. p. m. Month, Day, Year 19

20d. INJURY OCCURRED While at work ☐ Not while at work ☐

20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)

20f. (City or town) (County) (State)

21. I certify that I attended the deceased from Jan 15, 19 57, to Feb 6, 19 57, that I last saw the deceased alive on Feb 6, 19 57, and that death occurred at 8 00 a M, from the causes and on the date stated abave.

ACTUAL SIGNATURE: Wallace Obenshain M.D. — ADDRESS (Street, city or town, state): Cecilton, Md — DATE SIGNED: 8 Feb 57

PHYSICIAN'S NAME (Type): WALLACE OBENSHAIN

22a. BURIAL, CREMATION, REMOVAL (Specify): BURIAL — 22b. DATE THEREOF: 2/9/57 — 22c. NAME OF CEMETERY OR CREMATORY: CHESTER CEM. — 22d. LOCATION (City, town, or county) (State): CHESTERTOWN, MD.

23. FUNERAL DIRECTOR'S SIGNATURE: Edward Fellows. — ADDRESS: Millington, Md.

24a. REC'D BY REGISTRAR DATE: FEB 11 1957 — 24b. REGISTRAR'S SIGNATURE: Mrs. Ralph L. Reese

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be obtained by the hospitol or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled out by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registror prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A15 (4)
15M 9/55

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

01709

1693

CERTIFICATE OF DEATH

Reg. Dist. No. 9

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be obtained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A15 (4)
15M 9/55

1. PLACE OF DEATH
a. COUNTY: CECIL — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): ELKTON
c. LENGTH OF STAY IN 1b:
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION: UNION HOSPITAL

2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE: MD. — b. COUNTY: CECIL
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): XI EARLEVILLE, RURAL
d. STREET ADDRESS: 1
e. IS RESIDENCE ON A FARM? YES ☒ NO ☐

3. NAME OF DECEASED (Type or print): First CLARA — Middle EMMA — Last CRAIG

4. DATE OF DEATH: Month FEB — Day 27 — Year 1957

5. SEX: FEMALE

6. COLOR OR RACE: WHITE

7. MARRIED ☐ NEVER MARRIED ☐ WIDOWED ☒ DIVORCED ☐

8. DATE OF BIRTH: APRIL 4, 1883

9. AGE (In years last birthday): 73 yrs.
IF UNDER 1 YEAR / IF UNDER 24 HRS. — Months / Days / Hours / Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): HOUSEWIFE

10b. KIND OF BUSINESS OR INDUSTRY: HOME

11. BIRTHPLACE (State or foreign country): MD.

12. CITIZEN OF WHAT COUNTRY?: U. S. A.

13. FATHER'S NAME: PETER HAGGERTY

14. MOTHER'S MAIDEN NAME: ANNA MANNON

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) — (If yes, give war or dates of service):

16. SOCIAL SECURITY NO.: NONE

17. INFORMANT — Address: ALBERT CRAIG, CECILTON, MD.

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a): Cerebral Thrombosis — INTERVAL BETWEEN ONSET AND DEATH: 4 hours

241X

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.
DUE TO (b): Shock — 8 hours.
DUE TO (c): Acute Bronchial Asthma — Years.

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a): 420. Arteriosclerotic Heart Disease

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☒

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)

20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)

20c. TIME OF INJURY: Hour a. m. p. m. — Month, Day, Year 19

20d. INJURY OCCURRED: While at work ☐ Not while at work ☐

20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)

20f. (City or town) (County) (State)

21. I certify that I attended the deceased from Dec 1, 1956 to 27 Feb, 1957, that I last saw the deceased alive on 27 Feb, 1957, and that death occurred at 8:50 M, from the causes and on the date stated above.

ACTUAL SIGNATURE: Wallace Ovenshain MD M.D. — ADDRESS (Street, city or town, state): Cecilton, Md — DATE SIGNED: 1 Mar 57

PHYSICIAN'S NAME (Type):

22a. BURIAL, CREMATION, REMOVAL (Specify): BURIAL

22b. DATE THEREOF: 3/2/57

22c. NAME OF CEMETERY OR CREMATORY: BETHEL CEM.

22d. LOCATION (City, town, or county) (State): CHESAPEAKE CITY MD

23. FUNERAL DIRECTOR'S SIGNATURE: Edward Fellows, Millington, Md. — ADDRESS

24a. REC'D BY REGISTRAR — DATE: MAR 4 1957

24b. REGISTRAR'S SIGNATURE: L. R. Frazer

1

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

1711

CERTIFICATE OF DEATH

01710

Reg. Dist. No. 92

1. PLACE OF DEATH
a. COUNTY: Cecil — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Elk Mills
c. LENGTH OF STAY IN 1b: 11 years
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION:

2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE: Maryland
b. COUNTY: Cecil
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): X Elk Mills
d. STREET ADDRESS:
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print): First Martha; Middle Emma; Last Crookham

4. DATE OF DEATH: Month February; Day 3; Year 1957

5. SEX: Female

6. COLOR OR RACE: White

7. MARRIED ☐ NEVER MARRIED ☐ WIDOWED ☒ DIVORCED ☐

8. DATE OF BIRTH: July 16, 1874

9. AGE (In years last birthday): 82 yrs.
IF UNDER 1 YEAR: Months; Days
IF UNDER 24 HRS.: Hours; Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Housewife

10b. KIND OF BUSINESS OR INDUSTRY:

11. BIRTHPLACE (State or foreign country): Maryland

12. CITIZEN OF WHAT COUNTRY? USA

13. FATHER'S NAME: Armbrose Scotten

14. MOTHER'S MAIDEN NAME: Martha Brown

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown): no
(If yes, give war or dates of service):

16. SOCIAL SECURITY NO.:

17. INFORMANT: John W. Crookham, Address: Elk Mills, Maryland

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY:

		INTERVAL BETWEEN ONSET AND DEATH
IMMEDIATE CAUSE (a)	Chr. Interstitial Nephritis	2 yrs.
DUE TO (b)	Uremic Poisoning	2 wks.
DUE TO (c)	Hypertension	3 years

592X

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a): General Debility

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☒

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)

20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)

20c. TIME OF INJURY Month, Day, Year, Hour o. m. p. m. 19

20d. INJURY OCCURRED While at work ☐ Not while at work ☐

20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)

20f. (City or town) (County) (State)

21. I certify that I attended the deceased from Oct. 4, 1954 to February 3, 1957, that I last saw the deceased alive on Feb. 1, 1957, and that death occurred at 12:00 M, from the causes and on the date stated above.

ACTUAL SIGNATURE: James L. Johnson M.D. — ADDRESS (Street, city or town, state): Elkton, Md. — DATE SIGNED: February 4, 1957

PHYSICIAN'S NAME (Type): James L. Johnson MD

22a. BURIAL, CREMATION, REMOVAL (Specify): Burial

22b. DATE THEREOF: 2-6-57

22c. NAME OF CEMETERY OR CREMATORY: Cherry Hill Methodist Cem

22d. LOCATION (City, town, or county): Cherry Hill (State): Maryland

23. FUNERAL DIRECTOR'S SIGNATURE: Joseph R. Grant — ADDRESS: North East, Maryland

24a. REC'D BY REGISTRAR DATE: Feb 4

24b. REGISTRAR'S SIGNATURE: J R Fraze

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be obtained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A1S (4)
1SM 9/SS

1

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

CERTIFICATE OF DEATH

01711

Reg. Dist. No. 92

1. PLACE OF DEATH
a. COUNTY: Cecil — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): R.D. 4 ELKTON
c. LENGTH OF STAY IN 1b: 15 yrs
d. NAME OF HOSPITAL (If not in hospitol, give street oddress) OR INSTITUTION:

2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE: MARYLAND — b. COUNTY: Cecil
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): XI ELKTON, RURAL
d. STREET ADDRESS: RD #4
e. IS RESIDENCE ON A FARM? YES ☒ NO ☐

3. NAME OF DECEASED (Type or print): First Verdia — Middle I. — Last Crouse
4. DATE OF DEATH: Month February — Day 22 — Year 1957
5. SEX: Female
6. COLOR OR RACE: White
7. MARRIED ☐ NEVER MARRIED ☐ WIDOWED ☒ DIVORCED ☐
8. DATE OF BIRTH: July 2, 1877
9. AGE (In years last birthday): 79 yrs. — IF UNDER 1 YEAR: Months / Days — IF UNDER 24 HRS.: Hours / Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Housewife
10b. KIND OF BUSINESS OR INDUSTRY: Farming
11. BIRTHPLACE (State or foreign country): North Carolina
12. CITIZEN OF WHAT COUNTRY? U.S.A.
13. FATHER'S NAME: Mack Collins
14. MOTHER'S MAIDEN NAME: Jamamia Shupe
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown): No (If yes, give war or dates of service)
16. SOCIAL SECURITY NO.: None
17. INFORMANT: Dan Crouse, Chattham, Pa. — Address

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one couse per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a): Gastro-intestinal Hemorrage — INTERVAL BETWEEN ONSET AND DEATH: 12 hrs
445X
DUE TO (b): Malignant Hyper Tension — 5+ yrs
Conditions, if ony, which gove rise to immediote cose (a), stoting the underlying couse lost.
DUE TO (c): Generalized Arterio Sclerosis

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☒

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)
20b. DESCRIBE HOW INJURY OCCURRED. (Enter noture of injury in Port I or Port II of item 18.)
20c. TIME OF INJURY Hour o. m. p. m. Month, Doy, Year 19
20d. INJURY OCCURRED While at work ☐ Not while at work ☐
20e. PLACE OF INJURY (Home, form, factory, street, office bldg., etc.)
20f. (City or town) (County) (State)

21. I certify that I attended the deceased from June, 1956, to 22 Feb, 1957, that I last saw the deceased alive on 21 Feb, 1957, and that death occurred at 10:30 A M, from the causes and on the date stated above.

ACTUAL SIGNATURE: George J Kreis Jr M.D. — ADDRESS (Street, city or town, state): Elkton, Md — DATE SIGNED: 2/22/57
PHYSICIAN'S NAME (Type): George J. Kreis, Jr — EIKTON, MARYLAND

22a. BURIAL, CREMATION, REMOVAL (Specify): BURIAL
22b. DATE THEREOF: Feb 26, 1957
22c. NAME OF CEMETERY OR CREMATORY: Cherry Hill Meth Cem
22d. LOCATION (City, town, or county) (State): Cecil County, MARYLAND
23. FUNERAL DIRECTOR'S SIGNATURE: Ralph E. Hicks — ADDRESS: 103 Stockton St. Elkton Md
24a. REC'D BY REGISTRAR DATE 2/25/57
24b. REGISTRAR'S SIGNATURE: J R Frazer

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death: Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A1S (4)
15M 9/SS

1

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

01712

1713

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH
a. COUNTY: Cecil — MARYLAND

b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Rising Sun, Rural

c. LENGTH OF STAY IN 1b: 5 yrs

d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION: Graybeal Nursing Home

2. USUAL RESIDENCE (Where deceased lived. If institution, Residence before admission)
a. STATE: Md. — b. COUNTY: Cecil

c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): X Rising Sun

d. STREET ADDRESS:

e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print): First: Cecil — Middle: B — Last: Cummings

4. DATE OF DEATH: Month: Feb. — Day: 2 — Year: 1957

5. SEX: Male

6. COLOR OR RACE: White

7. MARRIED ☐ NEVER MARRIED ☒ WIDOWED ☐ DIVORCED ☐

8. DATE OF BIRTH: Sept. 23, 1869

9. AGE (In years last birthday): 87 yrs.

IF UNDER 1 YEAR: Months / Days — IF UNDER 24 HRS.: Hours / Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Retired Liveryman

10b. KIND OF BUSINESS OR INDUSTRY: Own Stables

11. BIRTHPLACE (State or foreign country): Pleasant Grove Pa.

12. CITIZEN OF WHAT COUNTRY?: U.S.

13. FATHER'S NAME: Henry Cummings

14. MOTHER'S MAIDEN NAME: Margaret Thompson

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown): no (If yes, give war or dates of service)

16. SOCIAL SECURITY NO.:

17. INFORMANT — Address: R.C.Dodson, Rising Sun, Md.

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a): Inanition — INTERVAL BETWEEN ONSET AND DEATH

450.0

DUE TO (b): General Aterioscleresis

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

DUE TO (c):

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(a) — 19. WAS AUTOPSY PERFORMED? YES ☐ NO ☐

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)

20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)

20c. TIME OF INJURY: Hour a. m. / p. m. — Month, Day, Year 19

20d. INJURY OCCURRED: While at work ☐ Not while at work ☐

20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) — 20f. (City or town) (County) (State)

21. I certify that I attended the deceased from 11-1-56, 19__, to 1-30-57, 19__, that I last saw the deceased alive on 1-28, 19 57, and that death occurred at 6 A. M, from the causes and on the date stated above.

ACTUAL SIGNATURE: R.C.Dodson M.D. — ADDRESS (Street, city or town, state): Rising Sun, Md, — DATE SIGNED:

PHYSICIAN'S NAME (Type): R.C.Dodson M.D.

22a. BURIAL, CREMATION, REMOVAL (Specify): Burial

22b. DATE THEREOF: Feb. 5, 1957

22c. NAME OF CEMETERY OR CREMATORY: West Nottingham

22d. LOCATION (City, town, or county) (State): Near Colora, Md.

23. FUNERAL DIRECTOR'S SIGNATURE — ADDRESS: J. Earl Tyson, Rising Sun Md

24a. REC'D BY REGISTRAR DATE: Feb 4-1-7

24b. REGISTRAR'S SIGNATURE: Lon Worthington

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be obtained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A15 (4)
15M 9/55

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

01713

1694

CERTIFICATE OF DEATH

Reg. Dist. No. 9

1. PLACE OF DEATH
a. COUNTY: Cecil
MARYLAND

2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE: Md.
b. COUNTY: CECIL

b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): ELKTON

c. LENGTH OF STAY IN 1b: 15 DAYS

c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): 21 ELKTON

d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION: UNION HOSP

d. STREET ADDRESS: 1 NORTH ST

e. IS RESIDENCE ON A FARM? YES ☐ NO ☑

3. NAME OF DECEASED (Type or print): First NELLIE Middle Last EVRIS

4. DATE OF DEATH: Month FEB Day 13 Year 1957

5. SEX: F.

6. COLOR OR RACE: W.

7. MARRIED ☑ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☐

8. DATE OF BIRTH: 1/17/1917

9. AGE (In years last birthday): 39 yrs.

IF UNDER 1 YEAR: Months / Days
IF UNDER 24 HRS.: Hours / Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): LABORER

10b. KIND OF BUSINESS OR INDUSTRY: GENERAL

11. BIRTHPLACE (State or foreign country): VIRGINIA

12. CITIZEN OF WHAT COUNTRY? USA

13. FATHER'S NAME: Thomas Coleman

14. MOTHER'S MAIDEN NAME: Mary Pierce

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) — (If yes, give war or dates of service)

16. SOCIAL SECURITY NO.

17. INFORMANT Address: Union Hosp. Records, ELKTON, Md

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a): Cirrhosis of the liver — INTERVAL BETWEEN ONSET AND DEATH: Unknown

581.0

DUE TO (b):

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

DUE TO (c):

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(a)

19. WAS AUTOPSY PERFORMED? YES ☑ NO ☐

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)

20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)

20c. TIME OF INJURY Hour a. m. p. m. Month, Day, Year 19

20d. INJURY OCCURRED While at work ☐ Not while at work ☐

20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)

20f. (City or town) (County) (State)

21. I certify that I attended the deceased from Jan 29, 19 57 to Feb 13, 19 57, that I last saw the deceased alive on Feb 12, 19 57, and that death occurred at 11:10 M, from the causes and on the date stated above.

ACTUAL SIGNATURE: S. Ralph Andrews Jr. M.D. ADDRESS (Street, city or town, state): 211 E Main St. Elkton, Md. DATE SIGNED: 2/14/57

PHYSICIAN'S NAME (Type): S. RALPH ANDREWS JR M.D.

22a. BURIAL, CREMATION, REMOVAL (Specify): Bury

22b. DATE THEREOF: Feb 16, 1957

22c. NAME OF CEMETERY OR CREMATORY: Sunny Slope Cemetery

22d. LOCATION (City, town, or county) (State): West Point, Virginia

23. FUNERAL DIRECTOR'S SIGNATURE: W Henry Peppas ADDRESS: Elkton, Md.

24a. REC'D BY REGISTRAR DATE: 2/15/57

24b. REGISTRAR'S SIGNATURE: H. Frazer

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A1S (4)
1SM 9/55

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

01714

CERTIFICATE OF DEATH

1714

Reg. Dist. No. 96

1. PLACE OF DEATH
a. COUNTY: Cecil — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Perry Point
c. LENGTH OF STAY IN 1b: 1month 7days

2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE: Maryland
b. COUNTY: Baltimore
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): 3701-4 Baltimore

d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION: Veterans Administration Hospital
d. STREET ADDRESS: 707 Aisquith Street
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print): First JAMES — Middle (NMI) — Last FINCH

4. DATE OF DEATH: Month February — Day 16 — Year 19 57

5. SEX: Male
6. COLOR OR RACE: Negro
7. MARRIED ☐ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☐
8. DATE OF BIRTH: February 11, 1910
9. AGE (In years last birthday): 47 yrs.
IF UNDER 1 YEAR: Months — Days
IF UNDER 24 HRS.: Hours — Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Parking Lot Attendant
10b. KIND OF BUSINESS OR INDUSTRY: Auto Parking Lot
11. BIRTHPLACE (State or foreign country): North Carolina
12. CITIZEN OF WHAT COUNTRY?: USA

13. FATHER'S NAME: HARRY FINCH
14. MOTHER'S MAIDEN NAME: MARY STONES

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown): Yes
(If yes, give war or dates of service): WW-II
16. SOCIAL SECURITY NO.: Unknown
17. INFORMANT — Address: Hospital Records, VAH., Perry Point, Md.

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a): Broncho pneumonia, bilateral, unresolved — INTERVAL BETWEEN ONSET AND DEATH: 4 To 5 Days
138.0
DUE TO
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.
(b) Uremia, uremic poisoning (Clinical) — 6 To 8 Wks.
DUE TO
(c) Sarcoidosis, generalized — Unknown

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(a): None
19. WAS AUTOPSY PERFORMED? YES ☒ NO ☐

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)
20c. TIME OF INJURY Hour a. m. p. m. — Month, Day, Year 19
20d. INJURY OCCURRED While at work ☐ Not while at work ☐
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)
20f. (City or town) (County) (State)

21. I certify that VA attended the deceased from January 9, 19 57, to February 16, 19 57, that I last saw the deceased alive on [illegible] 19[illegible], and that death occurred at 8:40A.M. from the causes and on the date stated above.

ACTUAL SIGNATURE: W. Oppler M.D.
ADDRESS (Street, city or town, state): V.A. Hospital, Perry Point, Md.
DATE SIGNED: 2-18-57
PHYSICIAN'S NAME (Type): W. OPPLER
Director, Professional Services

22a. BURIAL, CREMATION, REMOVAL (Specify): Removal
22b. DATE THEREOF: 2-17-57
22c. NAME OF CEMETERY OR CREMATORY: Sandy Level
22d. LOCATION (City, town, or county) (State): Bailey, North Carolina

23. FUNERAL DIRECTOR'S SIGNATURE — ADDRESS: PENNINGTON & SON, Havre DeGrace, Md.
24a. REC'D BY REGISTRAR DATE: 2-18-57
24b. REGISTRAR'S SIGNATURE: Irene E. Dougherty

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death: Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A15 (4)
15M 9/55

1

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

CERTIFICATE OF DEATH

1695

01715 92

Reg. Dist. No.

1. PLACE OF DEATH
a. COUNTY: Cecil
MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Elkton
c. LENGTH OF STAY IN 1b: 3 Hrs.
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION: Union Hospital

2. USUAL RESIDENCE (Where deceased lived. If institution, Residence before admission)
a. STATE: Md.
b. COUNTY: Cecil
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): X Rising Sun Rural
d. STREET ADDRESS: /
e. IS RESIDENCE ON A FARM? YES ☒ NO ☐

M

65

3. NAME OF DECEASED (Type or print): First Helen Middle Sterling Last Foster

4. DATE OF DEATH: Month Feb. Day 3 Year 1957

5. SEX: Female

6. COLOR OR RACE: White

7. MARRIED ☒ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☐

8. DATE OF BIRTH: April 17, 1889

9. AGE (In years last birthday): 67 yrs.
IF UNDER 1 YEAR: Months / Days
IF UNDER 24 HRS.: Hours / Min.

I

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Housewife

10b. KIND OF BUSINESS OR INDUSTRY: Own Home

11. BIRTHPLACE (State or foreign country): Rowlandville Md.

12. CITIZEN OF WHAT COUNTRY? U.S.

13. FATHER'S NAME: William Peeples

14. MOTHER'S MAIDEN NAME: Hannah Rawlings

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service): no

16. SOCIAL SECURITY NO.:

17. INFORMANT: Maynard Foster Address: Rising Sun, Md.

0

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a): 420.1 Acute Coronary
DUE TO
(b):
DUE TO
(c):

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

INTERVAL BETWEEN ONSET AND DEATH

0

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(a)

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☐

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)

20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)

20c. TIME OF INJURY Hour o. m. p. m. Month, Day, Year 19

20d. INJURY OCCURRED While at work ☐ Not while at work ☐

20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)

20f. (City or town) (County) (State)

0

1

21. I certify that I attended the deceased from 1-15-57, to 2-3-57, 19 57, that I last saw the deceased alive on 2-3-57, 19, and that death occurred at 7 A M, from the causes and on the date stated above.

ACTUAL SIGNATURE: R.C. Dodson M.D.
ADDRESS (Street, city or town, state): Rising Sun, Md,
DATE SIGNED: 2-4-57

PHYSICIAN'S NAME (Type): R.C. Dodson
R.C. Dodson

22a. BURIAL, CREMATION, REMOVAL (Specify): Burial

22b. DATE THEREOF: Feb. 7, 957

22c. NAME OF CEMETERY OR CREMATORY: Rosebank Cem.

22d. LOCATION (City, town, or county) (State): Near Rising Sun, Md.

23. FUNERAL DIRECTOR'S SIGNATURE: J. Earl Tyson. ADDRESS: Rising Sun Md

24a. REC'D BY REGISTRAR DATE: 2/5/57

24b. REGISTRAR'S SIGNATURE: H R Frazer

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A15 (4)
15M 9/55

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

01716

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

Reg. Dist. No. 9

1715

1. PLACE OF DEATH
a. COUNTY: Cecil — MARYLAND

2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE: Md. b. COUNTY: Cecil

b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Elkton. R.D.3

c. LENGTH OF STAY IN 1b: 20 yrs.

c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): X2 Elkton R.D.3

d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address)

d. STREET ADDRESS: / Andora

e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print): First: Harold Middle: Rivers Last: Gray

4. DATE OF DEATH: Month: 2 Day: 24 Year: 19 57

5. SEX: M

6. COLOR OR RACE: W

7. MARRIED ☐ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☐

8. DATE OF BIRTH: 9-5-1897

9. AGE (In years last birthday): 59 yrs.

IF UNDER 1 YEAR: Months: Days:
IF UNDER 24 HRS.: Hours: Min.:

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Laborer

10b. KIND OF BUSINESS OR INDUSTRY: All kinds of work Trainer, Pa.

11. BIRTHPLACE (State or foreign country): U.S.A.

12. CITIZEN OF WHAT COUNTRY?

13. FATHER'S NAME: Harry Rivers Gray

14. MOTHER'S MAIDEN NAME: Catherine Smith

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown): no (If yes, give war or dates of service)

16. SOCIAL SECURITY NO.:

17. INFORMANT: Address: Mrs. Alice Gray, E. Main St. Elkton, Md.

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a): Pistol shot above left Temple — INTERVAL BETWEEN ONSET AND DEATH: Instantly
976X
DUE TO (b):
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.
DUE TO (c):

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(a)

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☐

20a. EXTERNAL CAUSE WAS PRIMARY ☒ or CONTRIBUTING ☐ CAUSE OF DEATH.

20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.): Shot self with a pistol

20c. TIME OF INJURY: Hour a. m. p. m. Month, Day, Year: 2-24 19 57

20d. INJURY OCCURRED: While at work ☐ Not while at work ☒

20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.): Home

20f. (City or town) (County) (State): Elkton Cecil Md.

21. I certify that I took charge of the remains described above, held an Autopsy ☐, Inspection ☒ Inquiry ☒, and find that death resulted from: Natural causes ☐, Accident ☐, Suicide ☒, Homicide ☐, Undetermined cause ☐.

ACTUAL SIGNATURE: R.C. Dodson M.D.

CHIEF MEDICAL EXAMINER ☐
ASSISTANT MEDICAL EXAMINER ☐
DEPUTY MEDICAL EXAMINER ☒

DATE SIGNED: 3-2-57

EXAMINER'S NAME (Type): R.C. Dodson

22a. BURIAL, CREMATION, REMOVAL (Specify): Burial

22b. DATE THEREOF: 3-4-57

22c. NAME OF CEMETERY OR CREMATORY: North East Cemetery

22d. LOCATION (City, town, or county) (State): North East. Md.

23. FUNERAL DIRECTOR'S SIGNATURE: W Henry Poffin

ADDRESS: Elkton, Md.

24a. REC'D BY REGISTRAR DATE: 3/4/57

24b. REGISTRAR'S SIGNATURE: J R Frazer

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the registrar prior to burial, cremation or removal.

VS. A15ME(S)
5M 9/55

1

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

01717

1696

CERTIFICATE OF DEATH

Reg. Dist. No. 92

1. PLACE OF DEATH
a. COUNTY: Cecil — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Elkton
c. LENGTH OF STAY IN 1b: 1 hr

2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE: Md
b. COUNTY: Cecil
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): R.1 Elkton
d. STREET ADDRESS: 146 Hollingsworth Manor
e. IS RESIDENCE ON A FARM? YES ☐ NO ☐

d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION: Union Hospital

3. NAME OF DECEASED (Type or print): First Bobby Middle Lee Last Hamilton

4. DATE OF DEATH: Month Feb. Day 27 Year 1957

5. SEX	6. COLOR OR RACE	7. MARRIED ☐ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☐	8. DATE OF BIRTH	9. AGE (In years last birthday) yrs.	IF UNDER 1 YEAR: Months	Days	IF UNDER 24 HRS.: Hours	Min.
M	W		Feb. 27				1	

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country)	12. CITIZEN OF WHAT COUNTRY?
—	—	Elkton Maryland	U S A

13. FATHER'S NAME: Warner J. Hamilton

14. MOTHER'S MAIDEN NAME: Louise Martha Brown

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown)	(If yes, give war or dates of service)	16. SOCIAL SECURITY NO.	17. INFORMANT	Address
—	—	—	Warner J. Hamilton	Elkton Md

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a): Prematurity — INTERVAL BETWEEN ONSET AND DEATH: 1 hour
DUE TO
776X
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.
(b)
DUE TO
(c)

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☐

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)

20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)

20c. TIME OF INJURY Hour o. m. p. m. Month, Day, Year 19	20d. INJURY OCCURRED While at work ☐ Not while at work ☐	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town)	(County)	(State)

21. I certify that I attended the deceased from Feb 27, 1957, to Feb 27, 1957 that I last saw the deceased alive on Feb 27, 1957, and that death occurred at 4 PM, from the causes and on the date stated above.

ACTUAL SIGNATURE: Dr. M H Sprecher M.D.
ADDRESS (Street, city or town, state): Elkton, Md
DATE SIGNED: Feb 28, 1957
PHYSICIAN'S NAME (Type): M H Sprecher

22a. BURIAL, CREMATION, REMOVAL (Specify)	22b. DATE THEREOF	22c. NAME OF CEMETERY OR CREMATORY	22d. LOCATION (City, town, or county)	(State)
Burial	2/28/57	Cherry Hill Methodist Cem	Cherry Hill	Md

23. FUNERAL DIRECTOR'S SIGNATURE: W Walter duBois Jr. ADDRESS: Elkton Md

24a. REC'D BY REGISTRAR DATE 2/28/57

24b. REGISTRAR'S SIGNATURE: H H Frazer

20652141XVO

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A15 (4)
15M 9/55

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

01718

1716

CERTIFICATE OF DEATH

Reg. Dist. No. 17

1. PLACE OF DEATH
a. COUNTY: CECIL
MARYLAND

b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): BAINBRIDGE
c. LENGTH OF STAY IN 1b: 5 DAYS
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION: NAVAL HOSPITAL, BAINBRIDGE, MARYLAND

2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE: MARYLAND
b. COUNTY: CECIL
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): X2 PORT DEPOSIT
d. STREET ADDRESS: 18 A HENLEY PKWY., MANOR HEIGHTS
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print): First RICHMOND Middle ALFRED Last HANCOCK JR.

4. DATE OF DEATH: Month FEBRUARY Day 23 Year 1957

5. SEX: MALE
6. COLOR OR RACE: CAUCASIAN
7. MARRIED ☐ NEVER MARRIED ☒ WIDOWED ☐ DIVORCED ☐
8. DATE OF BIRTH: 18 FEBRUARY 1957
9. AGE (In years last birthday): 5 Days yrs.
IF UNDER 1 YEAR: Months Days 5
IF UNDER 24 HRS.: Hours Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)
10b. KIND OF BUSINESS OR INDUSTRY
11. BIRTHPLACE (State or foreign country): MARYLAND
12. CITIZEN OF WHAT COUNTRY? UNITED STATES

13. FATHER'S NAME: Richmond Alfred HANCOCK
14. MOTHER'S MAIDEN NAME: Dorothy Eloise SPEAKE

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown): NO (If yes, give war or dates of service)
16. SOCIAL SECURITY NO.
17. INFORMANT: RICHMOND ALFRED HANCOCK Address: 18 A HENLEY PKWY., MANOR HEIGHTS

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a): ATELECTASIS — INTERVAL BETWEEN ONSET AND DEATH

771.0

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

DUE TO (b): CEREBRAL ANOXIA

DUE TO (c): G. I. HEMORAGE, ETIOLOGY, UNDERTERMINED

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(a)

19. WAS AUTOPSY PERFORMED? YES ☒ NO ☐

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19
20d. INJURY OCCURRED While at work ☐ Not while at work ☐
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)
20f. (City or town) (County) (State)

21. I certify that I attended the deceased from February 18, 19 57, to February 23, 19 57, that I last saw the deceased alive on February 23, 19 57, and that death occurred at 0759A M, from the causes and on the date stated above.

ACTUAL SIGNATURE OF PHYSICIAN: A. J. Bisese M.D.
ADDRESS (Street, city or town, state): 6B Henley Pkwy., Port Deposit, Maryland
DATE SIGNED: 23 FEB 1957

PHYSICIAN'S NAME (Type): A. J. BISESE

22a. BURIAL, CREMATION, REMOVAL (Specify): BURIAL
22b. DATE THEREOF: 27 FEB 1957
22c. NAME OF CEMETERY OR CREMATORY: ARLINGTON NATIONAL
22d. LOCATION (City, town, or county) (State): ARLINGTON VIRGINIA

23. FUNERAL DIRECTOR'S SIGNATURE: Lee A Patterson & Son
ADDRESS: Perryville, Maryland
24a. REC'D BY REGISTRAR DATE: 23 FEB 1957
24b. REGISTRAR'S SIGNATURE: Dorothy L Brandle

2051282XVV

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A1S (4)
15M 9/55

1

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

01719

1697

CERTIFICATE OF DEATH

Reg. Dist. No. 92

1. PLACE OF DEATH
a. COUNTY Cecil MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) ELKton
c. LENGTH OF STAY IN 1b 6weeks
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Union Hospital

2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE Maryland b. COUNTY Cecil
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) x2 ELKton
d. STREET ADDRESS R.D. 3
e. IS RESIDENCE ON A FARM? [redacted] NO ☒

3. NAME OF DECEASED (Type or print) First Ethel Middle B. Last Headley

4. DATE OF DEATH Month Feb Day 22 Year 1957

5. SEX Female
6. COLOR OR RACE White
7. MARRIED ☐ NEVER MARRIED ☐ WIDOWED ☒ DIVORCED ☐
8. DATE OF BIRTH Oct 27 - [redacted] 1893
9. AGE (In years last birthday) 63 yrs.
IF UNDER 1 YEAR: Months ___ Days ___
IF UNDER 24 HRS.: Hours ___ Min. ___

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife
10b. KIND OF BUSINESS OR INDUSTRY —
11. BIRTHPLACE (State or foreign country) Camden N.J.
12. CITIZEN OF WHAT COUNTRY? U.S.a.

13. FATHER'S NAME Fred G. Booth
14. MOTHER'S MAIDEN NAME Lucy Kelly

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) No
16. SOCIAL SECURITY NO. None
17. INFORMANT Address Self - Hospital Records

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) Shock - -
260X
DUE TO (b) Amputation of Right Limb
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. DUE TO (c) Diabetic Gangrene

INTERVAL BETWEEN ONSET AND DEATH: (a) ___ (b) ___ (c) Indefinite

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(a)

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☒

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) —
20c. TIME OF INJURY Hour o. m. p. m. Month, Day, Year 19
20d. INJURY OCCURRED While at work ☐ Not while at work ☐
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)
20f. (City or town) (County) (State)

21. I certify that I attended the deceased from Jan 1, 1957, to Feb 22, 1957, that I last saw the deceased alive on Feb 17, 1957, and that death occurred at 12:30 P.M., from the causes and on the date stated above.

ACTUAL SIGNATURE H. A. Cantwell M.D. ADDRESS (Street, city or town, state) North East Maryland DATE SIGNED 2/27/57

PHYSICIAN'S NAME (Type) H. A. Cantwell — North East, Maryland

22a. BURIAL, CREMATION, REMOVAL (Specify) Burial
22b. DATE THEREOF Feb. 25, 1957
22c. NAME OF CEMETERY OR CREMATORY Cherry Hill Meth Cem.
22d. LOCATION (City, town, or county) (State) Cecil County Maryland

23. FUNERAL DIRECTOR'S SIGNATURE ADDRESS Ralph E. Hicks, 103 Stockton St, Elkton

24a. REC'D BY REGISTRAR DATE 2/25/57
24b. REGISTRAR'S SIGNATURE F. R. Frazer

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A15 (4)
1SM 9/55

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

01720

1717

CERTIFICATE OF DEATH

Reg. Dist. No. 96

1. PLACE OF DEATH
a. COUNTY: Cecil — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Perry Point
c. LENGTH OF STAY IN 1b: 8mos. 28days
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION: Veterans Administration Hospital

2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE: Maryland — b. COUNTY: Baltimore A.A.
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Marley Park, Glen Burnie 02x22
d. STREET ADDRESS: 31 Second Avenue
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print): First: FRANK — Middle: (NMI) — Last: HOLUB

4. DATE OF DEATH: Month: February — Day: 7, — Year: 1957

5. SEX: Male

6. COLOR OR RACE: White

7. MARRIED ☐ NEVER MARRIED ☐ WIDOWED ☒ DIVORCED ☐

8. DATE OF BIRTH: May 20, 1893

9. AGE (In years last birthday): 63 yrs.
IF UNDER 1 YEAR: Months / Days
IF UNDER 24 HRS.: Hours / Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Pressman

10b. KIND OF BUSINESS OR INDUSTRY: Newspaper

11. BIRTHPLACE (State or foreign country): Missouri

12. CITIZEN OF WHAT COUNTRY?: USA

13. FATHER'S NAME: FRANK HOLUB

14. MOTHER'S MAIDEN NAME: NELLIE TAYES

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown): Yes
(If yes, give war or dates of service): WW-I

16. SOCIAL SECURITY NO.: Unknown

17. INFORMANT — Address: Hospital Records, VAH., Perry Point, Maryland

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a): Pulmonary Edema, Massive, Bilateral — INTERVAL BETWEEN ONSET AND DEATH: 2 -3 Hours

420.0

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

DUE TO (b): Arteriosclerotic Heart Disease, Severe — Unknown

DUE TO (c): Myocardial fibrosis, Arteriosclerosis, generalized, severe — Unknown

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(a)

19. WAS AUTOPSY PERFORMED? YES ☒ NO ☐

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)

20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)

20c. TIME OF INJURY: Hour o. ft. p. m. — Month, Day, Year 19

20d. INJURY OCCURRED: While at work ☐ Not while at work ☐

20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)

20f. (City or town) (County) (State)

21. I certify that I attended the deceased from May 10, 1956 to February 7, 1957 that I last saw the deceased alive on [illegible], and that death occurred at 1:05 P.M., from the causes and on the date stated above.

ACTUAL SIGNATURE: W Oppler M.D. — ADDRESS (Street, city or town, state): Perry Point, Maryland — DATE SIGNED: 2-10-57

PHYSICIAN'S NAME (Type): W. OPPLER, M.D., Director, Professional Services, VAH., Perry Point, Md.

22a. BURIAL, CREMATION, REMOVAL (Specify): Removal

22b. DATE THEREOF: 2-9-57

22c. NAME OF CEMETERY OR CREMATORY: Western Cemetery

22d. LOCATION (City, town, or county) (State): Baltimore, Maryland

23. FUNERAL DIRECTOR'S SIGNATURE: Pennington & Son, PENNINGTON & SON — ADDRESS: Havre DeGrace, Md.

24a. REC'D BY REGISTRAR DATE: 2/13/57

24b. REGISTRAR'S SIGNATURE: Irene E. Daughaday

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A15 (4)
15M 9/55

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

01721

CERTIFICATE OF DEATH

1698

Reg. Dist. No. 92

1. PLACE OF DEATH
a. COUNTY: CECIL — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): ELKTON
c. LENGTH OF STAY IN 1b:
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION: UNION HOSPITAL

2. USUAL RESIDENCE (Where deceased lived. If institution, Residence before admission)
a. STATE: MD. — b. COUNTY: CECIL
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): XI FARLEVILLE
d. STREET ADDRESS: 1
e. IS RESIDENCE ON A FARM? YES ☒ NO ☐

3. NAME OF DECEASED (Type or print): First DORA — Middle — Last HURD

4. DATE OF DEATH: Month FEB. — Day 25 — Year 1957

5. SEX: F. — 6. COLOR OR RACE: W. — 7. MARRIED ☐ NEVER MARRIED ☐ WIDOWED ☒ DIVORCED ☐ — 8. DATE OF BIRTH: UNKNOWN 1894 — 9. AGE (In years last birthday): 63 yrs. — IF UNDER 1 YEAR: Months, Days — IF UNDER 24 HRS.: Hours, Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): HOUSEWORK — 10b. KIND OF BUSINESS OR INDUSTRY: HOME — 11. BIRTHPLACE (State or foreign country): MD. — 12. CITIZEN OF WHAT COUNTRY? U. S. A.

13. FATHER'S NAME: SAMUEL HURD — 14. MOTHER'S MAIDEN NAME: MARTHA BAILEY

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown): — (If yes, give war or dates of service): — 16. SOCIAL SECURITY NO.: NONE — 17. INFORMANT: Address: Mr. Herman Hurd Earleville Md.

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a): UREMIA. — INTERVAL BETWEEN ONSET AND DEATH: 1 months
DUE TO (b): KIDNEY FAILURE. NEPHROSCLEROSIS 3 years
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. — DUE TO (c):
442X

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a): GENERAL DEHYDRATION, ALIDOSIS, HEART FAILURE — 19. WAS AUTOPSY PERFORMED? YES ☐ NO ☒

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) — 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)

20c. TIME OF INJURY Month, Day, Year: Hour a. m. p. m. 19 — 20d. INJURY OCCURRED White at work ☐ Not while at work ☐ — 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) — 20f. (City or town) (County) (State)

21. I certify that I attended the deceased from 2-23, 1957, to 2-25, 1957, that I last saw the deceased alive on 2-25, 1957, and that death occurred at 3:30 P.M., from the causes and on the date stated above.

ACTUAL SIGNATURE: Otto Vogel M.D. — ADDRESS (Street, city or town, state): North East, Md. — DATE SIGNED: 2-25-57

PHYSICIAN'S NAME (Type): OTTO VOGEL, M.D

22a. BURIAL, CREMATION, REMOVAL (Specify): BURIAL — 22b. DATE THEREOF: FEB. 28, 1957 — 22c. NAME OF CEMETERY OR CREMATORY: CECILTON CEM. — 22d. LOCATION (City, town, or county) (State): CECILTON, CECIL Co., MD.

23. FUNERAL DIRECTOR'S SIGNATURE: Edward Sellman — ADDRESS: Millington, Md. — 24a. REC'D BY REGISTRAR DATE: MAR 1 1957 — 24b. REGISTRAR'S SIGNATURE: L. R. Frazer

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit. Then please remove carbon papers. Page 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A15 (4)
15M 9/55

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

CERTIFICATE OF DEATH

1718

01722

Reg. Dist. No. 94

1. PLACE OF DEATH
a. COUNTY: Cecil — MARYLAND

2. USUAL RESIDENCE (Where deceased lived. If institution, Residence before admission)
a. STATE: Maryland
b. COUNTY: Cecil
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): North East
c. LENGTH OF STAY IN 1b: all life
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): x2 North East
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION:
d. STREET ADDRESS:
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print): First: Verla — Middle: Laird — Last: KLine
4. DATE OF DEATH: Month: Feb — Day: 16 — Year: 1957

5. SEX: Fem
6. COLOR OR RACE: White
7. MARRIED ☒ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☐
8. DATE OF BIRTH: June 9, 1900
9. AGE (In years last birthday): 56 yrs.
IF UNDER 1 YEAR: Months / Days
IF UNDER 24 HRS.: Hours / Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Housewife
10b. KIND OF BUSINESS OR INDUSTRY:
11. BIRTHPLACE (State or foreign country): Maryland
12. CITIZEN OF WHAT COUNTRY? U.S.A.

13. FATHER'S NAME: Walter Laird
14. MOTHER'S MAIDEN NAME: Annie E. Lilley

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown): No
(If yes, give war or dates of service):
16. SOCIAL SECURITY NO.: 219-05-5260
17. INFORMANT: Frank W. Kline (Husband) — Address: North East, Md.

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a): Diabetes - Coma — INTERVAL BETWEEN ONSET AND DEATH
260X
DUE TO
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.
(b)
DUE TO
(c)

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(a)
19. WAS AUTOPSY PERFORMED? YES ☐ NO ☒

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)
20c. TIME OF INJURY Hour a. m. p. m. Month, Day, Year 19
20d. INJURY OCCURRED While at work ☐ Not while at work ☐
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)
20f. (City or town) (County) (State)

21. I certify that I attended the deceased from Dec 24, 1956, to Feb 16, 1957, that I last saw the deceased alive on Feb 15, 1957, and that death occurred at 11 A M, from the causes and on the date stated above.

ACTUAL SIGNATURE: H. A. Cantwell M D M.D. — ADDRESS (Street, city or town, state): North East, Md. — DATE SIGNED
PHYSICIAN'S NAME (Type): H. A. Cantwell — North East, Md.

22a. BURIAL, CREMATION, REMOVAL (Specify): BURIAL
22b. DATE THEREOF: 2-20-1957
22c. NAME OF CEMETERY OR CREMATORY: Methodist
22d. LOCATION (City, town, or county) (State): North East Maryland

23. FUNERAL DIRECTOR'S SIGNATURE: Joseph R Grant — ADDRESS: North East Md
24a. REC'D BY REGISTRAR DATE: 2-20-57
24b. REGISTRAR'S SIGNATURE: Sarah E. Rothermel

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death: Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 4 should be detached for use as the burial-transit permit. Then please remove carbon papers. Page 3 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A1S (4)
1SM 9/SS

1

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

1719

CERTIFICATE OF DEATH

01723

Reg. Dist. No. 94

1. PLACE OF DEATH
a. COUNTY: Cecil — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): North East (Rural)
c. LENGTH OF STAY IN 1b: 11 years
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION:

2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE: Maryland
b. COUNTY: Cecil
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): X / North East (Rural)
d. STREET ADDRESS: 1
e. IS RESIDENCE ON A FARM? YES [X] NO [ ]

3. NAME OF DECEASED (Type or print): First: Matti; Middle: T; Last: Laine

4. DATE OF DEATH: Month: February; Day: 25; Year: 1957

5. SEX: Male

6. COLOR OR RACE: White

7. MARRIED [X] NEVER MARRIED [ ] WIDOWED [ ] DIVORCED [ ]

8. DATE OF BIRTH: Oct. 8, 1892

9. AGE (In years last birthday): 64 yrs.
IF UNDER 1 YEAR: Months; Days
IF UNDER 24 HRS.: Hours; Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Farmer

10b. KIND OF BUSINESS OR INDUSTRY: Chicken

11. BIRTHPLACE (State or foreign country): Finland

12. CITIZEN OF WHAT COUNTRY? USA

13. FATHER'S NAME: John Laine

14. MOTHER'S MAIDEN NAME: Justiina Manumaa

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown): No
(If yes, give war or dates of service):

16. SOCIAL SECURITY NO.: 264-22-8578

17. INFORMANT: Mrs. Elsa M Laine — Address: North East, Md. R.D.

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a): Adenocarcinoma of right lung — INTERVAL BETWEEN ONSET AND DEATH: 1 yr.
DUE TO
163X
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.
(b):
DUE TO
(c):

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)

19. WAS AUTOPSY PERFORMED? YES [ ] NO [X]

20a. ACCIDENT WAS UNDERLYING [ ] OR CONTRIBUTING [ ] CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)

20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)

20c. TIME OF INJURY Hour a. m. p. m. Month, Day, Year 19

20d. INJURY OCCURRED While at work [ ] Not while at work [ ]

20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)

20f. (City or town) (County) (State)

21. I certify that I attended the deceased from 10 Dec, 1956, to 25 Feb, 1957, that I last saw the deceased alive on 25 Feb, 1957, and that death occurred at 7:50 P.M., from the causes and on the date stated above.

ACTUAL SIGNATURE: Klaus H. Huebner M.D.
ADDRESS (Street, city or town, state): North East, Md
DATE SIGNED:

PHYSICIAN'S NAME (Type): Klaus H. Huebner M.D

22a. BURIAL, CREMATION, REMOVAL (Specify): Burial
22b. DATE THEREOF: 2-28-57
22c. NAME OF CEMETERY OR CREMATORY: North East Meth. Cemetery
22d. LOCATION (City, town, or county) (State): North East Maryland

23. FUNERAL DIRECTOR'S SIGNATURE: Joseph R Grant
ADDRESS: North East, Md.

24a. REC'D BY REGISTRAR DATE: 2-28-57
24b. REGISTRAR'S SIGNATURE: Sarah E. Rothermel

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A1S (4)
15M 9/55

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

1693 CERTIFICATE OF DEATH

01724

Reg. Dist. No.

1. PLACE OF DEATH
a. COUNTY: Cecil — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Elkton
c. LENGTH OF STAY IN 1b: 5 days
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION: Union Hospital

2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE: Maryland — b. COUNTY: Cecil
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): ×2 Charlestown Post Office
d. STREET ADDRESS: Charlestown, Maryland
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print): First: Benjamin — Middle: K. — Last: Laughlin

4. DATE OF DEATH: Month: February — Day: 4 — Year: 1957

5. SEX: Male

6. COLOR OR RACE: White

7. MARRIED ☐ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☐

8. DATE OF BIRTH: Jan. 1, 1956

9. AGE (In years last birthday): 1 yrs. — IF UNDER 1 YEAR: Months: 1 Days: 1 — IF UNDER 24 HRS.: Hours: Min.:

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): ....

10b. KIND OF BUSINESS OR INDUSTRY: .....

11. BIRTHPLACE (State or foreign country): Maryland

12. CITIZEN OF WHAT COUNTRY? U. S. A.

13. FATHER'S NAME: Leon W. Laughlin

14. MOTHER'S MAIDEN NAME: Betty King

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown): ..... (If yes, give war or dates of service): .....

16. SOCIAL SECURITY NO.: .....

17. INFORMANT: Leon W. Laughlin — Address: Charlestown, Maryland

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a): Cardiac Failure (Circulatory Collapse) — INTERVAL BETWEEN ONSET AND DEATH: 12 hours
DUE TO
(b): Dehydration — 4/8 hours
DUE TO
(c): Infection - Pneumonia & Bronchitis — 3-4 days

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. 571.0

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☒

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)

20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)

20c. TIME OF INJURY Month, Day, Year: Hour a. m. p. m. 19

20d. INJURY OCCURRED While at work ☐ Not while at work ☐

20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)

20f. (City or town) (County) (State)

21. I certify that I attended the deceased from Jan. 28, 1957, to 4 Feb, 1957, that I last saw the deceased alive on 4 Feb, 1957, and that death occurred at 2:15 P.M. from the causes and on the date stated above.

ACTUAL SIGNATURE: George J. Kreis Jr. M.D. — ADDRESS (Street, city or town, state): Elkton, Md. — DATE SIGNED: 4 Feb, 1957

PHYSICIAN'S NAME (Type): George J. Kreis, Jr. — 201 E. Main St., Elkton, Maryland

22a. BURIAL, CREMATION, REMOVAL (Specify): Burial

22b. DATE THEREOF: Jan 7, 1957

22c. NAME OF CEMETERY OR CREMATORY: Oxford Cemetery

22d. LOCATION (City, town, or county) (State): Oxford, Pennsylvania

23. FUNERAL DIRECTOR'S SIGNATURE: Ralph E. Hicks — ADDRESS: 103 Stockton Street, Elkton, Maryland

24a. REC'D BY REGISTRAR DATE: 2/7/57

24b. REGISTRAR'S SIGNATURE: F R Fraser

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death: Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page [illegible] should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A15 (4)
15M 9/55

1

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

Items 13. & 14. Film G211, 3/7/57 bh

1720

01725

CERTIFICATE OF DEATH

Reg. Dist. No. 95

1. PLACE OF DEATH
a. COUNTY: Cecil — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Nottingham R.F.D.
c. LENGTH OF STAY IN 1b: 2 yrs
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION: Graybeal Nursing Home

2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE: Md.
b. COUNTY: Cecil
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Port Deposit X2
d. STREET ADDRESS: 1
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print): First: Henry; Middle: F.; Last: Lockard

4. DATE OF DEATH: Month: 2; Day: 28; Year: 1957

5. SEX: M

6. COLOR OR RACE: W

7. MARRIED ☐ NEVER MARRIED ☐ WIDOWED ☒ DIVORCED ☐

8. DATE OF BIRTH: 7-31-1868

9. AGE (In years last birthday): 88 yrs.
IF UNDER 1 YEAR: Months / Days
IF UNDER 24 HRS.: Hours / Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Fisherman and Woodman

10b. KIND OF BUSINESS OR INDUSTRY:

11. BIRTHPLACE (State or foreign country): Maryland

12. CITIZEN OF WHAT COUNTRY? U.S.A.

13. FATHER'S NAME: John J. Lockard

14. MOTHER'S MAIDEN NAME: Harriett Mahoney

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown): no
(If yes, give war or dates of service):

16. SOCIAL SECURITY NO.: none

17. INFORMANT: Mrs. John Burton, Colora, Md.
Address:

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a): Bilateral Bronchial Pneumonis — INTERVAL BETWEEN ONSET AND DEATH:
DUE TO
45a.0
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.
(b) Arteriosclerosis
DUE TO
(c)

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(a)

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☒

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)

20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)

20c. TIME OF INJURY: Hour a. m. / p. m. Month, Day, Year 19

20d. INJURY OCCURRED: While at work ☐ Not while at work ☐

20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)

20f. (City or town) (County) (State)

21. I certify that I attended the deceased from 2-26-57, 19 57, to 2-28-57, 19 57, that I last saw the deceased alive on 2-28-57, 19 ____, and that death occurred 8 P.M., from the causes and on the date stated above.

ACTUAL SIGNATURE: R.C.Dodson M.D. — ADDRESS (Street, city or town, state): Rising Sun Md. — DATE SIGNED: 3-1-57

PHYSICIAN'S NAME (Type): R.C.Dodson M.D. Rising Sun, Md.

22a. BURIAL, CREMATION, REMOVAL (Specify): Burial

22b. DATE THEREOF: 3-3-57

22c. NAME OF CEMETERY OR CREMATORY: Methodist North East, Md.

22d. LOCATION (City, town, or county) (State): North East, Md.

23. FUNERAL DIRECTOR'S SIGNATURE: Joseph R Grant
ADDRESS: North East, Md.

24c. REC'D BY REGISTRAR DATE: 3-3-57

24b. REGISTRAR'S SIGNATURE: Lem Worthington

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A1S (4)
15M 9/55

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

01727

Reg. Dist. No. 94

1721

1. PLACE OF DEATH
a. COUNTY: Cecil — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Principio Furnace
c. LENGTH OF STAY IN 1b: 49 yrs.
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address):

2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE: Md. — b. COUNTY: Cecil
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): X Principio Furnace
d. STREET ADDRESS:
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print): First: John — Middle: H. — Last: McDowell
4. DATE OF DEATH: Month: 2 — Day: 2 — Year: 19 57
5. SEX: M
6. COLOR OR RACE: W
7. MARRIED ☒ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☐
8. DATE OF BIRTH: 2-24-1877
9. AGE (In years last birthday): 79 yrs.
IF UNDER 1 YEAR: Months: — Days: —
IF UNDER 24 HRS.: Hours: — Min.: —
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Laborer
10b. KIND OF BUSINESS OR INDUSTRY: General
11. BIRTHPLACE (State or foreign country): Maryland
12. CITIZEN OF WHAT COUNTRY?: U.S.A.
13. FATHER'S NAME: William J. McDowell
14. MOTHER'S MAIDEN NAME: Milchia Clark
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown): no (If yes, give war or dates of service):
16. SOCIAL SECURITY NO.: 212-16-8044
17. INFORMANT: Rachel R. McDowell. Address: Principio Fur. Md.

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a): Acute Coronary Occlusion — INTERVAL BETWEEN ONSET AND DEATH:
420.1
DUE TO (b):
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. DUE TO (c):

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(a)
19. WAS AUTOPSY PERFORMED? YES ☐ NO ☒

20a. EXTERNAL CAUSE WAS PRIMARY ☐ or CONTRIBUTING ☐ CAUSE OF DEATH.
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)
20c. TIME OF INJURY: Hour a. m. p. m. — Month, Day, Year 19
20d. INJURY OCCURRED While at work ☐ Not while at work ☐
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)
20f. (City or town) (County) (State)

21. I certify that I took charge of the remains described above, held an Autopsy ☐, Inspection ☒, Inquiry ☒ and find that death resulted from: Natural causes ☒, Accident ☐, Suicide ☐, Homicide ☐, Undetermined cause ☐.

ACTUAL SIGNATURE: R.C. Dodson M.D. — CHIEF MEDICAL EXAMINER ☐ — ASSISTANT MEDICAL EXAMINER ☐ — DEPUTY MEDICAL EXAMINER ☒ — DATE SIGNED: 2-3-57
EXAMINER'S NAME (Type): R.C. Dodson

22a. BURIAL, CREMATION, REMOVAL (Specify): Burial
22b. DATE THEREOF: 2-5-57
22c. NAME OF CEMETERY OR CREMATORY: Principio Cemetery
22d. LOCATION (City, town, or county) (State): Principio Furnace Md.
23. FUNERAL DIRECTOR'S SIGNATURE: Joseph R Grant — ADDRESS: North East Md
24a. REC'D BY REGISTRAR DATE: 2-4-57
24b. REGISTRAR'S SIGNATURE: Sarah E. Rothermel

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your records.
TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.

VS. A15ME(5)
5M 9/55

1

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

CERTIFICATE OF DEATH

1700

01728

Reg. Dist. No. 92

1. PLACE OF DEATH
a. COUNTY: Cecil — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Elkton
c. LENGTH OF STAY IN 1b: 2 days
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION: Union Hospital

2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE: Maryland
b. COUNTY: Cecil
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Rural ×2
d. STREET ADDRESS: R. D. 3 Elkton, Md.
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print): First: Cecil; Middle: V.; Last: Moore

4. DATE OF DEATH: Month: February; Day: 24; Year: 1957

5. SEX: Male

6. COLOR OR RACE: White

7. MARRIED ☐ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☐

8. DATE OF BIRTH: March 18, 1900

9. AGE (In years last birthday): 56 yrs.
IF UNDER 1 YEAR: Months; Days
IF UNDER 24 HRS.: Hours; Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Engineer

10b. KIND OF BUSINESS OR INDUSTRY: Paper Mfg Elk Paper Co.

11. BIRTHPLACE (State or foreign country): Maryland

12. CITIZEN OF WHAT COUNTRY? U. S. A.

13. FATHER'S NAME: Theodore W. Moore

14. MOTHER'S MAIDEN NAME: Anna McDowell

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown): No
(If yes, give war or dates of service)

16. SOCIAL SECURITY NO.: 214-03-0872

17. INFORMANT — Address: Mrs. Bertha B. Moore, R. D 3 Elkton, Md.

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one couse per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a): Pulmonary Edema — INTERVAL BETWEEN ONSET AND DEATH: 5 hours
DUE TO (b): Coronary thrombosis — 3 days
DUE TO (c):

420.1

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☐

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)

20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)

20c. TIME OF INJURY: Hour; a. m. p. m.; Month; Day; Year 19

20d. INJURY OCCURRED: While at work ☐ Not while at work ☐

20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)

20f. (City or town) (County) (State)

21. I certify that I attended the deceased from 2/20, 1957, to 2/24, 1957, that I last saw the deceased alive on 2/23/57, 19____, and that death occurred at 7:30 A M, from the causes and on the date stated above.

ACTUAL SIGNATURE: J. Herbert Bates M.D.
ADDRESS (Street, city or town, state): 230 E Main st
DATE SIGNED: 2/25/57

PHYSICIAN'S NAME (Type): J HERBERT BATES
Elkton Md

22a. BURIAL, CREMATION, REMOVAL (Specify): Burial

22b. DATE THEREOF: Feb 27, 1957

22c. NAME OF CEMETERY OR CREMATORY: Cherry Hill Meth Cem.

22d. LOCATION (City, town, or county) (State): Cecil County, Maryland

23. FUNERAL DIRECTOR'S SIGNATURE: Ralph E. Hicks
ADDRESS: 103 Stockton Street Elkton, Maryland

24a. REC'D BY REGISTRAR DATE: 2/27/57

24b. REGISTRAR'S SIGNATURE: H R Frazer

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A15 (4)
15M 9/55

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

1722

CERTIFICATE OF DEATH

01729

Reg. Dist. No. 94

1. PLACE OF DEATH
a. COUNTY: Cecil — MARYLAND

2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE: Maryland b. COUNTY: Cecil

b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): North East
c. LENGTH OF STAY IN 1b: Lifetime

c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): X2 North East

d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION:

d. STREET ADDRESS: /

e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print): First: Vera Middle: C. Last: Nickle

4. DATE OF DEATH: Month: Feb. Day: 27 Year: 1957

5. SEX: Female

6. COLOR OR RACE: White

7. MARRIED ☐ NEVER MARRIED ☐ WIDOWED ☒ DIVORCED ☐

8. DATE OF BIRTH: Aug. 16, 1883

9. AGE (In years last birthday): 73 yrs.

IF UNDER 1 YEAR: Months: Days: IF UNDER 24 HRS.: Hours: Min.:

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Housewife

10b. KIND OF BUSINESS OR INDUSTRY:

11. BIRTHPLACE (State or foreign country): Maryland

12. CITIZEN OF WHAT COUNTRY? USA

13. FATHER'S NAME: ~~George~~ Guy B. Mackinson

14. MOTHER'S MAIDEN NAME: Jennie Hahn

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown): — (If yes, give war or dates of service):

16. SOCIAL SECURITY NO.: --

17. INFORMANT: Mrs. Cread F. Hyatt, Address: North East, Md.

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a): Myocardial Infarction — INTERVAL BETWEEN ONSET AND DEATH: 24 hours
DUE TO
(b): Uncontrolled diabetes mellitus — 12 years
DUE TO
(c):

260X

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a): none

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☐

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)

20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)

20c. TIME OF INJURY Hour o. m. p. m. Month, Day, Year 19

20d. INJURY OCCURRED While at work ☐ Not while at work ☐

20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)

20f. (City or town) (County) (State)

21. I certify that I attended the deceased from 2/26, 1957, to 2/27, 1957, that I last saw the deceased alive on 3/27, 1957, and that death occurred at 3 P.M., from the causes and on the date stated above.

ACTUAL SIGNATURE: Neil R Taylor M.D. ADDRESS (Street, city or town, state): Rising Sun, Md. DATE SIGNED: 2/28/57

PHYSICIAN'S NAME (Type): Neil R Taylor Jr. Rising Sun Md.

22a. BURIAL, CREMATION, REMOVAL (Specify): Burial

22b. DATE THEREOF: March 1, 1957

22c. NAME OF CEMETERY OR CREMATORY: Methodist

22d. LOCATION (City, town, or county) (State): North East, Cecil Co. Md.

23. FUNERAL DIRECTOR'S SIGNATURE: Joseph P Grant ADDRESS: North East, Maryland.

24a. REC'D BY REGISTRAR DATE: 2-28-57

24b. REGISTRAR'S SIGNATURE: Sarah E. Rothermel

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A1S (4)
15M 9/55

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

01730

Reg. Dist. No. 92

1723

1. PLACE OF DEATH
a. COUNTY: Cecil — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Elkton R.D.1
c. LENGTH OF STAY IN 1b: 1yr.
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address):

2. USUAL RESIDENCE (Where deceased lived. If Institution, Residence before admission)
a. STATE: Md — b. COUNTY: Cecil
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Elkton R.D.1
d. STREET ADDRESS:
e. IS RESIDENCE ON A FARM? YES ☐ NO ☐

3. NAME OF DECEASED (Type or print): First: Robin — Middle: Adelia — Last: Rice

4. DATE OF DEATH: Month: 2 — Day: 5 — Year: 1957

5. SEX: F — 6. COLOR OR RACE: W — 7. MARRIED ☐ NEVER MARRIED ☒ WIDOWED ☐ DIVORCED ☐ — 8. DATE OF BIRTH: 10-26-56 — 9. AGE (In years last birthday): yrs. — IF UNDER 1 YEAR: Months: 3, Days: 9 — IF UNDER 24 HRS.: Hours, Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Infant
10b. KIND OF BUSINESS OR INDUSTRY: Infant
11. BIRTHPLACE (State or foreign country): Havre Grace. Md.
12. CITIZEN OF WHAT COUNTRY? U.S.A.

13. FATHER'S NAME: Walter Leroy Rice
14. MOTHER'S MAIDEN NAME: Maxine Leora Messanger

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown): no (If yes, give war or dates of service):
16. SOCIAL SECURITY NO.: ----------
17. INFORMANT: Walter Leroy Rice. Address: Elkton. Md. R.D.1

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a): Smothered — INTERVAL BETWEEN ONSET AND DEATH:

924.0

DUE TO (b):

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. DUE TO (c):

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(a)

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☒

20a. EXTERNAL CAUSE WAS PRIMARY ☒ or CONTRIBUTING ☐ CAUSE OF DEATH.
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.): Down under covers and could not get air.
20c. TIME OF INJURY: Hour 1 a. m. p. m. — Month, Day, Year: 2 5 1957
20d. INJURY OCCURRED: While at work ☐ Not while at work ☒
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.): Home
20f. (City or town) Elkton (County) Cecil (State) Md

21. I certify that I took charge of the remains described above, held an Autopsy ☐, Inspection ☒ Inquiry ☒ and find that death resulted from: Natural causes ☐, Accident ☒ Suicide ☐, Homicide ☐, Undetermined cause ☐.

ACTUAL SIGNATURE: R.C. Dodson M.D. — CHIEF MEDICAL EXAMINER ☐ — ASSISTANT MEDICAL EXAMINER ☐ — DEPUTY MEDICAL EXAMINER ☒ — DATE SIGNED

EXAMINER'S NAME (Type): R.C. Dodson — 205057

22a. BURIAL, CREMATION, REMOVAL (Specify): Burial
22b. DATE THEREOF: 2/7/57
22c. NAME OF CEMETERY OR CREMATORY: Gilpin Manor
22d. LOCATION (City, town, or county): Elkton (State) Md

23. FUNERAL DIRECTOR'S SIGNATURE: W. Henry Pippin — ADDRESS: Elkton Md.
24a. REC'D BY REGISTRAR DATE: 2/7/57
24b. REGISTRAR'S SIGNATURE: J R Frazer

2071181XV3

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.

VS. A15ME(5)
5M 9/55

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

CERTIFICATE OF DEATH

1724

01731

Reg. Dist. No. 96

1. PLACE OF DEATH
a. COUNTY: Cecil — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Perry Point
c. LENGTH OF STAY IN 1b: 7yrs. 7mo. 22days
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION: Veterans Administration Hospital

2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE: Virginia
b. COUNTY:
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Richmond 83x-3
d. STREET ADDRESS: 321 W. Grace
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print): First ELLIS Middle F. Last ROURKE

4. DATE OF DEATH: Month February Day 19 Year 1957

5. SEX: Male

6. COLOR OR RACE: White

7. MARRIED ☐ NEVER MARRIED ☐ WIDOWED ☒ DIVORCED ☐

8. DATE OF BIRTH: December 20, 1908

9. AGE (In years last birthday): 48 yrs.

IF UNDER 1 YEAR: Months ___ Days ___
IF UNDER 24 HRS.: Hours ___ Min. ___

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Salesman

10b. KIND OF BUSINESS OR INDUSTRY: unknown

11. BIRTHPLACE (State or foreign country): Pennsylvania

12. CITIZEN OF WHAT COUNTRY?: USA

13. FATHER'S NAME: George Rourke

14. MOTHER'S MAIDEN NAME: Annie Cole

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown): Yes (If yes, give war or dates of service): WW II

16. SOCIAL SECURITY NO.: unknown

17. INFORMANT Address: Hospital Records, VAH, Perry Point, Md.

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a): Bronchopneumonia, right lung, unresolved — INTERVAL BETWEEN ONSET AND DEATH: 5 days

420.0

DUE TO

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

(b) Arteriosclerotic heart disease, severe — unknown

DUE TO

(c)

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a): 002x Tuberculosis, pulmonary, left upper lobe - unknown

19. WAS AUTOPSY PERFORMED? YES ☒ NO ☐

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)

20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)

20c. TIME OF INJURY Hour a. m. p. m. Month, Day, Year 19

20d. INJURY OCCURRED While at work ☐ Not while at work ☐

20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)

20f. (City or town) (County) (State)

VA

21. I certify that I attended the deceased from June 28, 1949, to February 19, 1957 that I last saw the deceased alive on [illegible] 19[illegible] and that death occurred at 10:20a M, from the causes and on the date stated above.

ACTUAL SIGNATURE: [signature] M.D. ADDRESS (Street, city or town, state): V.A. Hospital, Perry Point, Md. DATE SIGNED: 2-20-57

PHYSICIAN'S NAME (Type): W. OPPLER — Director, Professional Services

22a. BURIAL, CREMATION, REMOVAL (Specify): removal

22b. DATE THEREOF: 2-20-57

22c. NAME OF CEMETERY OR CREMATORY: Baltimore National

22d. LOCATION (City, town, or county) (State): Baltimore, Md.

23. FUNERAL DIRECTOR'S SIGNATURE ADDRESS: Pennington & Son, Havre de Grace, Md.

24a. REC'D BY REGISTRAR DATE: 2-21-57

24b. REGISTRAR'S SIGNATURE: Irene E. Dougherty

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 4 should be detached for use as the burial-transit permit. Then please remove carbon papers. Page 3 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A15 (4)
15M 9/55

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

1725

CERTIFICATE OF DEATH

01732

Reg. Dist. No.

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A15 (4)
15M 9/55

1. PLACE OF DEATH a. COUNTY: Cecil — MARYLAND	2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE: Maryland b. COUNTY: Cecil
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): R. D. 1 Elkton, Md. — c. LENGTH OF STAY IN 1b: 32 years	c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): R. D. 1 Elkton, Maryland
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION	d. STREET ADDRESS — e. IS RESIDENCE ON A FARM? YES ☒ NO ☐

3. NAME OF DECEASED (Type or print)	First: MICHAEL	Middle	Last: SAFIA	4. DATE OF DEATH	Month: February	Day: 8	Year: 19 57	
5. SEX: Male	6. COLOR OR RACE: White	7. MARRIED ☒ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☐	8. DATE OF BIRTH: Jan 6, 1895	9. AGE (In years last birthday): 62 yrs.	IF UNDER 1 YEAR: Months / Days	IF UNDER 24 HRS.: Hours / Min.		

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Retired Crossing Watchman	10b. KIND OF BUSINESS OR INDUSTRY: Penna. R. R.	11. BIRTHPLACE (State or foreign country): Poland	12. CITIZEN OF WHAT COUNTRY? U. S. A.
13. FATHER'S NAME: John Safia		14. MOTHER'S MAIDEN NAME: Unknown	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown): No (If yes, give war or dates of service)	16. SOCIAL SECURITY NO.: 716-01-7572	17. INFORMANT: Mrs. Josephine Safia (Wife)	Address: R. D. 1 Elkton, Md.

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

		INTERVAL BETWEEN ONSET AND DEATH
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a)	Coronary Occlusion	1 Day
002X DUE TO		
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) DUE TO	Myocourdial Infarct	8 mos.
(c)	Pulmonary TB. (Diagnosis made John Hopkins	5mos.

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(a): None - Operated on at John Hopkins - 3 weeks ago

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☒

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)

20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)

20c. TIME OF INJURY Hour / Month, Day, Year	20d. INJURY OCCURRED	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
o. m. / p. m. 19	While at work ☐ Not while at work ☐		

21. I certify that I attended the deceased from Oct. 19 56, to Feb. 8 19 57, that I last saw the deceased alive on Feb. 7 19 57, and that death occurred at 5:30 P.M., from the causes and on the date stated above.

ACTUAL SIGNATURE: Jacob J. Greenwald M.D. — ADDRESS (Street, city or town, state): 202 E. Main St. Elkton, Md. — DATE SIGNED: Feb, 9- 57

PHYSICIAN'S NAME (Type): Jacob J. Greenwald, M.D.

22a. BURIAL, CREMATION, REMOVAL (Specify)	22b. DATE THEREOF	22c. NAME OF CEMETERY OR CREMATORY	22d. LOCATION (City, town, or county) (State)
Burial	Feb 12, 1957	Immaculate Conception	Elkton, Maryland

23. FUNERAL DIRECTOR'S SIGNATURE	ADDRESS	24a. REC'D BY REGISTRAR DATE	24b. REGISTRAR'S SIGNATURE
Ralph E. Hicks	103 Stockton Street Elkton, Maryland	2/12/57	H R Fraser

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

1701

CERTIFICATE OF DEATH

01733

Reg. Dist. No. 92

1. PLACE OF DEATH
a. COUNTY: Cecil
MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Elkton
c. LENGTH OF STAY IN 1b: 10yrs.
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION: 340 Hollingsworth Manor

2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE: Md.
b. COUNTY: Cecil
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Elkton
d. STREET ADDRESS: 340 Hollingsworth Manor
e. IS RESIDENCE ON A FARM? YES ☐ NO ☐

3. NAME OF DECEASED (Type or print): First: Laura Middle: Belle Last: Sanders

4. DATE OF DEATH: Month: Feb. Day: 21 Year: 1957

5. SEX: Female

6. COLOR OR RACE: White

7. MARRIED ☒ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☐

8. DATE OF BIRTH: 12/7/24

9. AGE (In years last birthday): 32 yrs.
IF UNDER 1 YEAR: Months / Days
IF UNDER 24 HRS.: Hours / Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): House Wife

10b. KIND OF BUSINESS OR INDUSTRY: Housekeeping

11. BIRTHPLACE (State or foreign country): Va.

12. CITIZEN OF WHAT COUNTRY? U.S.A.

13. FATHER'S NAME: Arter Hays

14. MOTHER'S MAIDEN NAME: Dora Brooks

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown): No (If yes, give war or dates of service)

16. SOCIAL SECURITY NO.: 227-24-7247

17. INFORMANT: Elton Sanders Address:

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a): Carcinoma of the uterus — INTERVAL BETWEEN ONSET AND DEATH: Over 10 months
DUE TO: with metastase to lungs
174X
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.
(b)
DUE TO
(c)

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(a)

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☐

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)

20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)

20c. TIME OF INJURY Month, Day, Year: Hour o. m. p. m. 19

20d. INJURY OCCURRED While at work ☐ Not while at work ☐

20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)

20f. (City or town) (County) (State)

21. I certify that I attended the deceased from Feb. 18, 1957, to Feb. 21, 1957, that I last saw the deceased alive on Feb. 21, 1957, and that death occurred at 10 A. M., from the causes and on the date stated above.

ACTUAL SIGNATURE: S. Ralph Andrews, Jr. M.D.
ADDRESS (Street, city or town, state): 233 E. Main St. Elkton, Md.
DATE SIGNED: 2/21/57

PHYSICIAN'S NAME (Type): S. RALPH ANDREWS, JR. M.D.

22a. BURIAL, CREMATION, REMOVAL (Specify): Burial
22b. DATE THEREOF: 2/23/57
22c. NAME OF CEMETERY OR CREMATORY: Elkton Cem.
22d. LOCATION (City, town, or county) (State): Elkton Md.

23. FUNERAL DIRECTOR'S SIGNATURE: H. Walter Lee Boal Jr.
ADDRESS: Elkton Md

24a. REC'D BY REGISTRAR DATE: 2/23/57
24b. REGISTRAR'S SIGNATURE: H R Frazer

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A15 (4)
15M 9/55

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

1702

CERTIFICATE OF DEATH

01734

Reg. Dist. No. 92

1. PLACE OF DEATH
a. COUNTY: Cecil — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Elkton, Maryland
c. LENGTH OF STAY IN 1b: 20 years
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION: Union Hospital

2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE: Maryland
b. COUNTY: Cecil
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Elkton, 21
d. STREET ADDRESS: Cathedral Street
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print): First FRANK Middle S. Last SCARBOROUGH

4. DATE OF DEATH: Month February Day 10 Year 19 57

5. SEX: Male

6. COLOR OR RACE: White

7. MARRIED ☒ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☐

8. DATE OF BIRTH: July 18, 1909

9. AGE (In years last birthday): 47 yrs.
IF UNDER 1 YEAR: Months ___ Days ___
IF UNDER 24 HRS.: Hours ___ Min. ___

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Attendant

10b. KIND OF BUSINESS OR INDUSTRY: Service Station

11. BIRTHPLACE (State or foreign country): Maryland

12. CITIZEN OF WHAT COUNTRY? U. S. A.

13. FATHER'S NAME: Mathew G. Scarborough

14. MOTHER'S MAIDEN NAME: Margaret Gregg

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown): No
(If yes, give war or dates of service):

16. SOCIAL SECURITY NO.: 216-05-3886

17. INFORMANT Address: Josephine Scarborough, Elkton, Maryland

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a): Arteriosclerosis H. D. & Congestive H. F. — INTERVAL BETWEEN ONSET AND DEATH: 5 days
260X
DUE TO (b): Cirrhosis of Liver
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.
DUE TO (c): Diabetes Mellitus

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☒

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)

20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)

20c. TIME OF INJURY Hour ___ a. m. p. m. Month ___ Day ___ Year 19 ___

20d. INJURY OCCURRED While at work ☐ Not while at work ☐

20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)

20f. (City or town) (County) (State)

21. I certify that I attended the deceased from 2-5-57, to 2-10-57, that I last saw the deceased alive on 2-10-57, and that death occurred at 7:15 P.M., from the causes and on the date stated above.

ACTUAL SIGNATURE: Sarah Fong Sung M.D. — ADDRESS (Street, city or town, state): Union Hospital, Elkton, Md. — DATE SIGNED: 2-10-57

PHYSICIAN'S NAME (Type): Sarah Fong Sung, M.D. — Union Hospital, Elkton, Md.

22a. BURIAL, CREMATION, REMOVAL (Specify): Burial

22b. DATE THEREOF: Feb 13 1957

22c. NAME OF CEMETERY OR CREMATORY: Sharps Cemetery

22d. LOCATION (City, town, or county) (State): Cecil County, Maryland

23. FUNERAL DIRECTOR'S SIGNATURE: Ralph E. Hicks — ADDRESS: 103 Stockton Street, Elkton, Maryland

24a. REC'D BY REGISTRAR DATE: 2/12/57

24b. REGISTRAR'S SIGNATURE: [illegible]

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 4 should be detached for use as the burial-transit permit. Then please remove carbon papers. Page 3 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A15 (4)
15M 9/55

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

CERTIFICATE OF DEATH

1703

01735

Reg. Dist. No. 92

1

M

65

1

1

0

0

1

1

1. PLACE OF DEATH
a. COUNTY: Cecil — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Elkton
c. LENGTH OF STAY IN 1b: 4 days
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION: Union Hospital

2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE: Maryland
b. COUNTY: Cecil
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): x2 North East
d. STREET ADDRESS: 1
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print): First SHEREE Middle JEAN Last SIMPERS

4. DATE OF DEATH: Month 2 Day 22 Year 1957

5. SEX: Female

6. COLOR OR RACE: White

7. MARRIED ☐ NEVER MARRIED ☒ WIDOWED ☐ DIVORCED ☐

8. DATE OF BIRTH: March 27, 1955

9. AGE (In years last birthday): 1 yrs.
IF UNDER 1 YEAR: Months ___ Days ___
IF UNDER 24 HRS.: Hours ___ Min. ___

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)

10b. KIND OF BUSINESS OR INDUSTRY

11. BIRTHPLACE (State or foreign country): Elkton, Maryland

12. CITIZEN OF WHAT COUNTRY? USA

13. FATHER'S NAME: Robert W. Simpers

14. MOTHER'S MAIDEN NAME: Sarah E. Fears

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown): —
(If yes, give war or dates of service)

16. SOCIAL SECURITY NO.: —

17. INFORMANT: Robert W. Simpers Father
Address: North East, Md.

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a): ADRENAL INSUFFICIENCY — INTERVAL BETWEEN ONSET AND DEATH: 4 days
DUE TO
578X
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.
(b): GASTRO INTESTINAL INFECTION — 7 days
DUE TO
(c):

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(a): CIRCULATORY FAILURE

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☐

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)

20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)

20c. TIME OF INJURY Hour a. m. p. m. Month, Day, Year 19

20d. INJURY OCCURRED While at work ☐ Not while at work ☐

20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)

20f. (City or town) (County) (State)

21. I certify that I attended the deceased from 2-17, 1957, to 2-22, 1957, that I last saw the deceased alive on 2-22-57, 19___, and that death occurred at 6 A M, from the causes and on the date stated above.

ACTUAL SIGNATURE: Otto Vogel M.D.
ADDRESS (Street, city or town, state): North East, Md.
DATE SIGNED: 2-23-57
PHYSICIAN'S NAME (Type): OTTO VOGEL, MD

22a. BURIAL, CREMATION, REMOVAL (Specify): Burial
22b. DATE THEREOF: 2-24-57
22c. NAME OF CEMETERY OR CREMATORY: North East Methodist Cem.
22d. LOCATION (City, town, or county) (State): North East Maryland

23. FUNERAL DIRECTOR'S SIGNATURE: Joseph R Grant
ADDRESS: North East, Md.

24a. REC'D BY REGISTRAR DATE: 2/23/57

24b. REGISTRAR'S SIGNATURE: J R Frazier

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A1S (4)
1SM 9/SS

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

CERTIFICATE OF DEATH

1726

01736 96 Reg. Dist. No.

1. PLACE OF DEATH
a. COUNTY: Cecil — MARYLAND

2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE: Maryland b. COUNTY:

b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Perry Point

c. LENGTH OF STAY IN 1b: 9yrs.10mo.28days

c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Baltimore 3 W 01-4

d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION: Veterans Administration Hospital

d. STREET ADDRESS: 1105 Peach

e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print): First OLIVER Middle T. Last SNOWDEN

4. DATE OF DEATH: Month February Day 3 Year 1957

5. SEX: Male

6. COLOR OR RACE: Negro

7. MARRIED ☐ NEVER MARRIED ☒ WIDOWED ☐ DIVORCED ☐

8. DATE OF BIRTH: March 20, 1895

9. AGE (In years last birthday): 61 yrs.

IF UNDER 1 YEAR: Months Days — IF UNDER 24 HRS.: Hours Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Unknown

10b. KIND OF BUSINESS OR INDUSTRY: Unknown

11. BIRTHPLACE (State or foreign country): Maryland

12. CITIZEN OF WHAT COUNTRY? USA

13. FATHER'S NAME: William Snowden

14. MOTHER'S MAIDEN NAME: Eliza (?)

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown): Yes (If yes, give war or dates of service): WW I

16. SOCIAL SECURITY NO.: Unknown

17. INFORMANT Address: Hospital Records, VAH, Perry Point, Md.

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

		INTERVAL BETWEEN ONSET AND DEATH
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a)	Pyelonephritis, organism unknown	unknown
DUE TO (b)	Renal calculi, multiple, type unknown	unknown
DUE TO (c)	Bronchopneumonia, both lower lobes, unresolved	7-10 days

602x

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a): Agenesis of right kidney (unknown)

19. WAS AUTOPSY PERFORMED? YES ☒ NO ☐

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)

20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)

20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. VA 19

20d. INJURY OCCURRED While at work ☐ Not while at work ☐

20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)

20f. (City or town) (County) (State)

21. I certify that ~~I attended~~ the deceased from March 6, 1947, to February 3, 1957, ~~and I last saw the deceased~~ ~~gave on~~, and that death occurred at 9:35 a.m., from the causes and on the date stated above.

ACTUAL SIGNATURE: W. Oppler M.D.

ADDRESS (Street, city or town, state): V.A. Hospital, Perry Point, Md.

DATE SIGNED: 2-4-57

PHYSICIAN'S NAME (Type): W. OPPLER

Director, Professional Services

22a. BURIAL, CREMATION, REMOVAL (Specify): Removal

22b. DATE THEREOF: 2-4-57

22c. NAME OF CEMETERY OR CREMATORY: Baltimore National

22d. LOCATION (City, town, or county) (State): Baltimore, Md.

23. FUNERAL DIRECTOR'S SIGNATURE: Pennington & Son

ADDRESS: Havre de Grace, Md.

24a. REC'D BY REGISTRAR DATE: Feb. 5 1957

24b. REGISTRAR'S SIGNATURE: Diane E. Wangberg

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A15 (4)
15M 9/55

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

CERTIFICATE OF DEATH

1727

01737
Reg. Dist. No.

1. PLACE OF DEATH
a. COUNTY: CECIL — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): CALVERT
c. LENGTH OF STAY IN 1b: 11 Mo.
d. NAME OF HOSPITAL OR INSTITUTION: GRAYBEALS NURSING HOME

2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE: N.J.
b. COUNTY: CAMDEN
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): CAMDEN
d. STREET ADDRESS: 67 x 3
e. IS RESIDENCE ON A FARM? YES ☐ NO ☐

3. NAME OF DECEASED (Type or print): First: OTHNIEL — Middle: G — Last: STACKHOUSE

4. DATE OF DEATH: Month: FEB — Day: 6 — Year: 1957

5. SEX: MALE

6. COLOR OR RACE: WHITE

7. MARRIED ☐ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☐

8. DATE OF BIRTH: APRIL 30, 1865

9. AGE (In years last birthday): 91 yrs.
IF UNDER 1 YEAR: Months / Days
IF UNDER 24 HRS.: Hours / Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): CLERK

10b. KIND OF BUSINESS OR INDUSTRY: TALKING MACHINE CO

11. BIRTHPLACE (State or foreign country): CAMDEN, N.J.

12. CITIZEN OF WHAT COUNTRY?: U.S.A.

13. FATHER'S NAME: DAVID T. STACKHOUSE

14. MOTHER'S MAIDEN NAME: MARGARET KERRIGEN

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown): NO
(If yes, give war or dates of service):

16. SOCIAL SECURITY NO.: NONE

17. INFORMANT: MIRIAM FOGG — Address: NORTH EAST, MD.

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a): Cerebral Accident — INTERVAL BETWEEN ONSET AND DEATH
331X
DUE TO
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.
(b): Arteriosclerosis
DUE TO
(c):

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☐

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)

20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)

20c. TIME OF INJURY: Hour o. m. p. m. — Month, Day, Year 19

20d. INJURY OCCURRED: While at work ☐ Not while at work ☐

20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)

20f. (City or town) (County) (State)

21. I certify that I attended the deceased from 11-1, 19 56 to 2-6-57, 19 ____, that I last saw the deceased alive on 2-5-57, 19 ____, and that death occurred at 1P M, from the causes and on the date stated above.

ACTUAL SIGNATURE: R.C. Dodson M.D.
ADDRESS (Street, city or town, state): Rising Sun, Md.
DATE SIGNED: 2-6-57

PHYSICIAN'S NAME (Type): R.C. Dodson MD

22a. BURIAL, CREMATION, REMOVAL (Specify): BURIAL
22b. DATE THEREOF: 2/8/57
22c. NAME OF CEMETERY OR ~~CREMATORY~~: EVERGREEN
22d. LOCATION (City, town, or county): CAMDEN (State): N.J.

23. FUNERAL DIRECTOR'S SIGNATURE AND ADDRESS: Ralph M Reed, Rising Sun, Md.

24a. REC'D BY REGISTRAR (Date): Feb 7-57

24b. REGISTRAR'S SIGNATURE: [illegible]

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A15 (4)
15M 9/55

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

CERTIFICATE OF DEATH

01738

1. 1704

Reg. Dist. No. 92

1. PLACE OF DEATH
a. COUNTY: Cecil — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Elkton
c. LENGTH OF STAY IN 1b: —
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION: Union Hospital

2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE: Maryland
b. COUNTY: Cecil
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): X2 North East
d. STREET ADDRESS: 1
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print): First: Baby — Middle: Boy — Last: Stevens

4. DATE OF DEATH: Month: 2 — Day: 4 — Year: 1957

5. SEX: Male

6. COLOR OR RACE: White

7. MARRIED ☐ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☐

8. DATE OF BIRTH: 2-3-1957

9. AGE (In years last birthday) yrs.

IF UNDER 1 YEAR: Months — Days — IF UNDER 24 HRS.: Hours 9 — Min. 33

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): none

10b. KIND OF BUSINESS OR INDUSTRY: —

11. BIRTHPLACE (State or foreign country): Elkton Maryland

12. CITIZEN OF WHAT COUNTRY? U.S.A.

13. FATHER'S NAME: Wilbur Blakley

14. MOTHER'S MAIDEN NAME: Yvonne Stevens

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service):

16. SOCIAL SECURITY NO.:

17. INFORMANT: Address: Gladys Stevens North East Md

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a): Prematurity (lb. 3 3) — INTERVAL BETWEEN ONSET AND DEATH: 10 hrs.
DUE TO (b): (Premature Separation of Placenta)
DUE TO (c):

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. 761.0

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(a): —

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☒

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)

20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) —

20c. TIME OF INJURY Hour o. m. p. m. — Month, Day, Year — 19

20d. INJURY OCCURRED While at work ☐ Not while at work ☐

20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) —

20f. (City or town) — (County) — (State) —

21. I certify that I attended the deceased from 3 Feb, 1957, to 4 Feb, 1957, that I last saw the deceased alive on 4 Feb, 1957, and that death occurred at 7:30 A. M, from the causes and on the date stated above.

ACTUAL SIGNATURE: Klaus H. Hueber M.D. — ADDRESS (Street, city or town, state): No. 44 E. st, Md — DATE SIGNED: 4 Feb 57

PHYSICIAN'S NAME (Type): Klaus H. Hueber M.D. — No. 44 E. st, Md

22a. BURIAL, CREMATION, REMOVAL (Specify): Burial

22b. DATE THEREOF: 2-4-1957

22c. NAME OF CEMETERY OR CREMATORY: Methodist

22d. LOCATION (City, town, or county) (State): North East, Cecil Co. Md

23. FUNERAL DIRECTOR'S SIGNATURE: Joseph R Brant — ADDRESS: North East. Md

24a. REC'D BY REGISTRAR DATE: 2/4/57

24b. REGISTRAR'S SIGNATURE: F R Frazer

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A15 (4)
15M 9/55

20 65203 X V0

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

1705 CERTIFICATE OF DEATH

01739

Reg. Dist. No. 92

1. PLACE OF DEATH
a. COUNTY: Cecil — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Elkton
c. LENGTH OF STAY IN 1b: Life
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION: 218 E. Main St.

2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE: Md. — b. COUNTY: Cecil
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Elkton,
d. STREET ADDRESS: 218 E. Main St.
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print): First: Lillian — Middle: Alexander — Last: Sykes

4. DATE OF DEATH: Month: February — Day: 19 — Year: 1957

5. SEX: F

6. COLOR OR RACE: Wh

7. MARRIED ☐ NEVER MARRIED ☐ WIDOWED ☒ DIVORCED ☐

8. DATE OF BIRTH: Sept. 23, 1872

9. AGE (In years last birthday): 84 yrs.
IF UNDER 1 YEAR: Months / Days
IF UNDER 24 HRS.: Hours / Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): House Wife

10b. KIND OF BUSINESS OR INDUSTRY: House Work

11. BIRTHPLACE (State or foreign country): Elkton, Md.

12. CITIZEN OF WHAT COUNTRY? U. S. A.

13. FATHER'S NAME: John E. Alexander

14. MOTHER'S MAIDEN NAME: Martha J. Robinson

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)

16. SOCIAL SECURITY NO.

17. INFORMANT (Address): Mrs. G. Leslie Timme. Abington, Pa.

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a): Cerebral Hemorrhage — INTERVAL BETWEEN ONSET AND DEATH: 1 day
DUE TO
442X
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.
(b): Cardio vascular renal — 10 yrs
DUE TO
(c):

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a): Rheumatoid Arthritis

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☒

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)

20b. DESCRIBE HOW INJURY OCCURRED. (Enter noture of injury in Part I or Part II of item 18.)

20c. TIME OF INJURY Month, Day, Year: Hour a. m. p. m. — 1/ — 1/ 19 57

20d. INJURY OCCURRED While at work ☐ Not while at work ☒

20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.): Home

20f. (City or town) Elkton (County) Cecil (State) Md

21. I certify that I attended the deceased from ____, 19 33, to 2/19, 1957, that I last saw the deceased alive on 2/19, 1957, and that death occurred at 6 P. M, from the causes and on the date stated above.

ACTUAL SIGNATURE: J Herbert Bates M.D.
ADDRESS (Street, city or town, state): Elkton Md
DATE SIGNED: 2/20/57
PHYSICIAN'S NAME (Type): J. HERBERT BATES

22a. BURIAL, CREMATION, REMOVAL (Specify): Burial
22b. DATE THEREOF: 2-22-1957
22c. NAME OF CEMETERY OR CREMATORY: Elkton Cemetery
22d. LOCATION (City, town, or county) (State): Elkton, Md.

23. FUNERAL DIRECTOR'S SIGNATURE: W Henry Pippin
ADDRESS: 257 E. Main St Elkton Md
24a. REC'D BY REGISTRAR DATE: 2/23/57
24b. REGISTRAR'S SIGNATURE: I R Frazer

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A15 (4)
15M 9/55

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

01740

1728

CERTIFICATE OF DEATH

Reg. Dist. No. 96

1. PLACE OF DEATH
a. COUNTY: Cecil — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Perry Point
c. LENGTH OF STAY IN 1b: 3mo.27days
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION: Veterans Administration Hospital

2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE: D. C. — b. COUNTY
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): 47x-3 Washington
d. STREET ADDRESS: 1735 Park Road, N.W.
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print): First RAYMOND — Middle P. — Last TALBOTT
4. DATE OF DEATH: Month February — Day 12 — Year 1957
5. SEX: Male
6. COLOR OR RACE: White
7. MARRIED ☐ NEVER MARRIED ☐ WIDOWED ☒ DIVORCED ☐
8. DATE OF BIRTH: 11-8-95
9. AGE (In years last birthday): 61 yrs.
IF UNDER 1 YEAR: Months — Days
IF UNDER 24 HRS.: Hours — Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Cook
10b. KIND OF BUSINESS OR INDUSTRY: Hotel
11. BIRTHPLACE (State or foreign country): Kansas
12. CITIZEN OF WHAT COUNTRY? USA

13. FATHER'S NAME: Thomas O. Talbott - deceased
14. MOTHER'S MAIDEN NAME: Mary E. Hardesty - deceased

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown): Yes
(If yes, give war or dates of service): WWmI
16. SOCIAL SECURITY NO.: unknown
17. INFORMANT — Address: Hospital Records, VAH, Perry Point, Md.

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a): Cirrhosis of liver — INTERVAL BETWEEN ONSET AND DEATH: unknown
581.0
DUE TO
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.
(b)
DUE TO
(c)

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(a)

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☒

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)
20c. TIME OF INJURY Hour a. m. p. m. — Month, Day, Year 19
20d. INJURY OCCURRED While at work ☐ Not while at work ☐
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)
20f. (City or town) (County) (State)
VA

21. I certify that I attended the deceased from October 16, 1956, to February 12, 1957 ~~last saw the deceased alive~~ ~~Give on~~ ~~, 19~~ and that death occurred at 12:55 A.M., from the causes and on the date stated above.

ACTUAL SIGNATURE: W. Oppler — M.D. — ADDRESS (Street, city or town, state): V.A. Hospital, Perry Point, Md. — DATE SIGNED: 2-14-57

PHYSICIAN'S NAME (Type): W. OPPLER — Director, Professional Services

22a. BURIAL, CREMATION, REMOVAL (Specify): Removal
22b. DATE THEREOF: 2-14-57
22c. NAME OF CEMETERY OR CREMATORY: Arlington National
22d. LOCATION (City, town, or county) (State): Arlington, Virginia

23. FUNERAL DIRECTOR'S SIGNATURE — ADDRESS: Pennington & Son, Havre de Grace, Md.
24a. REC'D BY REGISTRAR DATE: 2/15/57
24b. REGISTRAR'S SIGNATURE: Irene E. Daugherty

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 4 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A15 (4)
15M 9/55

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

1706

CERTIFICATE OF DEATH

01741

Reg. Dist. No. 9-2

1. PLACE OF DEATH
a. COUNTY: Cecil — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Elkton
c. LENGTH OF STAY IN 1b: 20 years
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION: 192 E Main St

2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE: Md — b. COUNTY: Cecil
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): 21 Elkton
d. STREET ADDRESS: 192 E Main St
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print): First: Marion — Middle: J — Last: Thompson

4. DATE OF DEATH: Month: February — Day: 28 — Year: 1957

5. SEX: M

6. COLOR OR RACE: Wh.

7. MARRIED ☒ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☐

8. DATE OF BIRTH: August 16, 1879

9. AGE (In years last birthday): 77 yrs.
IF UNDER 1 YEAR: Months / Days
IF UNDER 24 HRS.: Hours / Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Retired
10b. KIND OF BUSINESS OR INDUSTRY: Salesman

11. BIRTHPLACE (State or foreign country): Stormstown, Pa

12. CITIZEN OF WHAT COUNTRY? U. S. A.

13. FATHER'S NAME: Andrew J. Thompson

14. MOTHER'S MAIDEN NAME: Mary Chambers Hartnock

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)

16. SOCIAL SECURITY NO.: 213-03-0600

17. INFORMANT: Mrs. M. J. Thompson — Address: 192 E. Main St Elkton, Md.

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a): Cerebral hemorrhage — INTERVAL BETWEEN ONSET AND DEATH: 2 weeks
DUE TO (b): Hypertensive arteriosclerotic Cardiovascular disease — Several years
DUE TO (c):

443x

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(a)

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☐

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)

20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)

20c. TIME OF INJURY Hour a. m. p. m. Month, Day, Year 19

20d. INJURY OCCURRED While at work ☐ Not while at work ☐

20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)

20f. (City or town) (County) (State)

21. I certify that I attended the deceased from March 14, 1953, to Feb. 28, 1957, that I last saw the deceased alive on Feb. 22, 1957, and that death occurred at 4 P M, from the causes and on the date stated above.

ACTUAL SIGNATURE: S Ralph Andrews, Jr. M.D.
ADDRESS (Street, city or town, state): 231 E. Main St. Elkton Md.
DATE SIGNED: 3/1/57

PHYSICIAN'S NAME (Type): S. RALPH ANDREWS JR

22a. BURIAL, CREMATION, REMOVAL (Specify): Burial
22b. DATE THEREOF: 3-3-1957
22c. NAME OF CEMETERY OR CREMATORY: Friends Cemetery
22d. LOCATION (City, town, or county) (State): Calvert Md.

23. FUNERAL DIRECTOR'S SIGNATURE: Henry Coffin Elkton, Md. — ADDRESS

24a. REC'D BY REGISTRAR DATE: 3/4/57
24b. REGISTRAR'S SIGNATURE: H R Ferguson

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A15 (4)
15M 9/55

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

1729

CERTIFICATE OF DEATH

01742

Reg. Dist. No. 96

1. PLACE OF DEATH
a. COUNTY: Cecil — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Perry Point
c. LENGTH OF STAY IN 1b: 7 mo. 2 days
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION: Veterans Administration Hospital

2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE: Maryland
b. COUNTY: Baltimore
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): 0355 Towson
d. STREET ADDRESS: 29 Linden Terrace
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print): First WILLIAM — Middle J. — Last WOELFEL JR.

4. DATE OF DEATH: Month February — Day 12 — Year 1957

5. SEX: Male

6. COLOR OR RACE: White

7. MARRIED ☒ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☐

8. DATE OF BIRTH: 8-29-96

9. AGE (In years last birthday): 60 yrs.

IF UNDER 1 YEAR: Months — Days — IF UNDER 24 HRS.: Hours — Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Clerk

10b. KIND OF BUSINESS OR INDUSTRY: Payroll

11. BIRTHPLACE (State or foreign country): Pennsylvania

12. CITIZEN OF WHAT COUNTRY?: USA

13. FATHER'S NAME: William J. Woelfel,Sr.

14. MOTHER'S MAIDEN NAME: Mary McDevitt

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown): Yes
(If yes, give war or dates of service): WW I

16. SOCIAL SECURITY NO.: unknown

17. INFORMANT — Address: Hospital Records, VAH, Perry Point, Md.

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a): Myocardial fibrosis, left ventricle — INTERVAL BETWEEN ONSET AND DEATH: unknown
420.0
DUE TO
(b): Arteriosclerotic heart disease, severe — unknown
DUE TO
(c): Arteriosclerosis, general, severe — unknown

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(a)

19. WAS AUTOPSY PERFORMED? YES ☒ NO ☐

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)

20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)

20c. TIME OF INJURY Hour a. m. p. m. — Month, Day, Year 19

20d. INJURY OCCURRED While at work ☐ Not while at work ☐

20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)

20f. (City or town) (County) (State)

21. I certify that VA attended the deceased from July 10, 1956, to February 12, 1957, that I last saw the deceased alive on [illegible], and that death occurred at 7:45 a.m., from the causes and on the date stated above.

ACTUAL SIGNATURE: W. Oppler, M.D. — ADDRESS (Street, city or town, state): V.A. Hospital, Perry Point, Md. — DATE SIGNED: 2-12-57

PHYSICIAN'S NAME (Type): W. Oppler — Director, Professional Services

22a. BURIAL, CREMATION, REMOVAL (Specify): removal

22b. DATE THEREOF: 2-12-57

22c. NAME OF CEMETERY OR CREMATORY: Baltimore National

22d. LOCATION (City, town, or county) (State): Baltimore, Md.

23. FUNERAL DIRECTOR'S SIGNATURE — ADDRESS: John Burns' Sons, 610-612 York Rd. Towson, Md.

24a. REC'D BY REGISTRAR DATE: 2/15/57

24b. REGISTRAR'S SIGNATURE: Irene Daughtery

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death: Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 4 should be detached for use as the burial-transit permit. Then please remove carbon papers. Page 3 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A15 (4)
15M 9/55

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

01743

1707

CERTIFICATE OF DEATH

Reg. Dist. No. 92

1. PLACE OF DEATH
a. COUNTY: Cecil — MARYLAND

2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE: Md. b. COUNTY: Cecil

b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Elkton
c. LENGTH OF STAY IN 1b:
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Chesapeake City x 2

d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION: Union Hospital
d. STREET ADDRESS: 1
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print): First: Carrie Middle: Potter Last: Wright
4. DATE OF DEATH: Month: February Day: 3 Year: 1957

5. SEX: F
6. COLOR OR RACE: Wh
7. MARRIED ☐ NEVER MARRIED ☒ WIDOWED ☐ DIVORCED ☐
8. DATE OF BIRTH: July 29, 1877
9. AGE (In years last birthday): 79 yrs.
IF UNDER 1 YEAR: Months / Days
IF UNDER 24 HRS.: Hours / Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): At Home
10b. KIND OF BUSINESS OR INDUSTRY: House Work
11. BIRTHPLACE (State or foreign country): Cambridge Md.
12. CITIZEN OF WHAT COUNTRY?: U. S. A.

13. FATHER'S NAME: Thomas H. Wright
14. MOTHER'S MAIDEN NAME: Margaret Keen

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service):
16. SOCIAL SECURITY NO.:
17. INFORMANT: Mrs. Berkley Address:

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a): Cerebral hemorrhage — INTERVAL BETWEEN ONSET AND DEATH: 1 day
442 X
DUE TO
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.
(b): Cardio vascular renal — 5 yrs.
DUE TO
(c):

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(a)

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☐

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)
20c. TIME OF INJURY Hour a. m. p. m. Month, Day, Year 19
20d. INJURY OCCURRED While at work ☐ Not while at work ☐
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)
20f. (City or town) (County) (State)

21. I certify that I attended the deceased from Feb 2, 19 57, to Feb 3, 19 57, that I last saw the deceased alive on Feb 3, 19 57, and that death occurred at 11:30 P. M., from the causes and on the date stated above.

ACTUAL SIGNATURE: J. Herbert Bates M.D.
ADDRESS (Street, city or town, state): Elkton Md
DATE SIGNED: Feb 4-57
PHYSICIAN'S NAME (Type): J. HERBERT BATES

22a. BURIAL, CREMATION, REMOVAL (Specify): Burial
22b. DATE THEREOF: 2-6-1957
22c. NAME OF CEMETERY OR CREMATORY: St. Roses Catholic
22d. LOCATION (City, town, or county) (State): Chesapeake City, Md.

23. FUNERAL DIRECTOR'S SIGNATURE: C. Henry Kilgore
ADDRESS: Elkton, Md.
24a. REC'D BY REGISTRAR DATE: 2/7/57
24b. REGISTRAR'S SIGNATURE: F R Frazer

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be detached by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A15 (4)
15M 9/55